

**Behavioral Health Services
and
Arizona State Hospital**

**ANNUAL REPORT
FISCAL YEAR 1997**



Jane Dee Hull, Governor

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JANE DEE HULL, GOVERNOR
JAMES R. ALLEN, M.D., M.P.H.

January 1, 1999

The Honorable Jane Dee Hull
Governor
State of Arizona
1700 W. Washington
Phoenix, AZ 85007

Dear Governor Hull:

I am pleased to present the Annual Report for Arizona Department of Health Services/Behavioral Health Services and the Arizona State Hospital for Fiscal Year 1997. This report is prepared in accordance with A.R.S. 36-3405 and 36-209(E). The report combines the annual reports for Behavioral Health Services and the Arizona State Hospital and reflects the activities of various components of these service areas.

I pledge our continued efforts toward a system which provides quality behavioral health services to those in need and which is accountable to the citizens of this State.

Sincerely,

A handwritten signature in black ink, appearing to read "J. Allen", written over a faint, larger "J. Allen" watermark.

James R. Allen, M.D., M.P.H.
Director

**Behavioral Health Services
and**

Arizona State Hospital

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**Submitted in Compliance with
A.R.S. § 36-3405 and 36-209(e)**



~Leadership for a Healthy Arizona~

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INTRODUCTION

The Arizona Department of Health Services, Behavioral Health Services (ADHS/BHS) continues to provide leadership in activities designed to more effectively meet the needs of Arizona residents. ADHS/BHS is committed to delivering quality, cost-effective services through a managed care environment

The behavioral health service delivery system envisioned for the future is one in which a fully developed and integrated continuum of care is available in urban and rural areas. This comprehensive array of services will be community based, culturally sensitive, family focused, and will build on the strengths of the client, bringing about the greatest degree of recovery possible in a timely manner.

ADHS/BHS has embarked upon a strategic planning process designed to guide it into the next century as it continues to meet new challenges. To guide in this process, a vision, mission statement, and guiding principles were developed.

VISION FOR THE BEHAVIORAL HEALTH SYSTEM

We envision an accountable and accessible behavioral health system. This system provides for responsive, comprehensive, community-based services tailored to the individual, family, community and culture. It does this to promote healthy development and to provide effective prevention, evaluation, treatment and intervention services to people in need who would otherwise go unserved, so that people are empowered and can lead responsible, productive, meaningful lives. It reduces the costs to society from behavioral health problems and improves quality of life for the people we serve and for society.

MISSION STATEMENT

The mission of Behavioral Health Services is to continually improve the effectiveness and efficiency of a comprehensive system of behavioral health care in order to meet the needs of the people of Arizona.

PRINCIPLES

The Behavioral Health Services Management Team is committed to achieving excellence in the development and delivery of behavioral health, prevention and treatment services through adherence to the following principles:

1. **Effective Leadership** We value and promote leadership with integrity at all levels within the service system. Through coaching, counseling, mentoring and sharing of information we provide a supportive work environment where decisions are made at the levels most responsive to the customer.
2. **Innovation and Creativity** We challenge the status quo to find better ways to coordinate, integrate and enhance services for the people we serve.
3. **Service Philosophy** We value the input of all our stakeholders and the people we serve. We believe in building excellent relationships which reflect mutual responsibility and respect for BHS stakeholders and the people we serve.
4. **Healthy Living** We encourage and promote responsible living and regard prevention services and health promotion as an integral part of the behavioral health service delivery system.
5. **Public Stewardship** We accept the responsibility for the proper use of public resources in ways that optimize benefits to the public.
6. **Continuous Quality Improvement** We measure the efficiency and effectiveness of the delivery of care to provide continuous feedback to stakeholders and internal decision makers. Performance measures are outcome based and are selected for their usefulness in achieving the purpose of improving performance and of responding to customer's changing needs.
7. **Commitment to Employees** We recruit and retain a professional, culturally diverse team. We provide opportunities for life long learning.
8. **Development of Partnerships** We forge partnerships to achieve mutual goals through open communication, honoring commitments, and fostering trust.

HISTORY OF BEHAVIORAL HEALTH SERVICES

The Arizona Department of Health Services is the State agency responsible for public health education, prevention and treatment. The Division of Behavioral Health Services (BHS) is the largest Division of the Department, both in number of staff and size of budget.

Behavioral Health Services was recreated within ADHS by Arizona Revised Statutes 36-3402 et. seq., effective August 13, 1986. The intent of the Arizona Legislature was to create permanent authority for behavioral health and to express a commitment to the importance of behavioral health services in Arizona. BHS serves as the single state authority to provide coordination, planning, administration, regulation and monitoring of all facets of the state public behavioral health system. BHS has the responsibility of administering a system of behavioral health care which is responsive, individualized, cost efficient, culturally sensitive and equally accessible.

DESCRIPTION OF THE BEHAVIORAL HEALTH SERVICE DELIVERY SYSTEM

Section 36-3410 of Arizona Revised Statutes authorizes ADHS/BHS to contract with community based organizations, known as Regional Behavioral Health Authorities (RBHAs), to administer behavioral health services in the State. These RBHAs are private organizations, and function in a fashion similar to a managed care organization. The State is divided into six geographic regions with a RBHA responsible for each region. See Appendix A for a map of the geographic service areas.

RBHAs are responsible for assessing the service needs in their region through a community planning process and developing a plan to meet those needs. RBHAs contract with a network of more than 350 service providers statewide to deliver a full range of behavioral health care services, including prevention programs for adults and children, and a full continuum of services for adults with substance abuse and general mental health disorders, adults with serious mental illness, and children with serious emotional disturbance.

RBHAs receive a capitated payment from ADHS/DBHS to deliver Title XIX Medicaid services. RBHAs receive monthly payments from all other non-Medicaid resources to serve non-Title XIX populations.

In addition to the RBHA system, BHS has developed several options for the delivery of behavioral health services to American Indians, both on and off the reservation. American Indians who live off the reservation may access services through the RBHA system in the same manner as any other Arizona resident. For American Indians who live on a reservation, the Tribe has the option of: (a) entering into an Intergovernmental Agreement (IGA) with ADHS to deliver behavioral health services on the reservation, with the reservation acting as its own RBHA; (b) contracting with the local RBHA to provide services; or (c) allowing on-reservation Tribal members to obtain behavioral health services either through Indian Health Service, or going off reservation to receive services.

ORGANIZATIONAL STRUCTURE OF BEHAVIORAL HEALTH SERVICES

The Assistant Director and Deputy Assistant Director provide leadership and direction in accomplishing the mission of BHS. An Organizational Chart is included in Appendix B. The management team, which is composed of Bureau Chiefs, oversees the following functions:

Fiscal Management - **The Bureau of Administrative Support Services** provides oversight and coordination of BHS financial and operational functions to ensure efficient, effective, and accountable operations in accordance with federal and state laws and regulations and Department policies. Functions include fiscal monitoring and budget, provider services, procurement and personnel services. This Bureau has provided leadership in the development of financial standards to assure a healthy balance of the fiscal viability of the system and the needs of the clients it serves.

Planning - **The Bureau of Planning and Council Support** has responsibility for establishing strategic vision and direction for publicly funded behavioral health services in Arizona. The BHS planning process occurs at all levels of the system and ensures the involvement of all stakeholders in the process. BHS receives input from four advisory councils, and through regional public planning meetings. The BHS budget request process is an integral component of planning, as required by the State's Budget Reform Act. The planning process includes the production of a three-year plan, with annual reviews and reports of progress.

Program Development - **The Bureau for Persons with Serious Mental Illness; the Bureau of Children's Services; the Bureau of Substance Abuse and General Mental Health; and the Bureau of Prevention** are responsible for the design, development and provision of technical assistance to the RBHAs and provider community in each program area. These offices provide leadership in establishing standards of performance, designing outcome indicators and identifying best practices.

Clinical Oversight - **The Office of the Medical Director** provides clinical oversight in the provision of behavioral health services. Working closely with the Medical Directors of the RBHAs, the Medical Director develops clinical practice guidelines which are used throughout the State. The Medical Director also coordinates with the Medical Director of AHCCCS and with AHCCCS Health Plans for the joint management of clients' physical and behavioral health needs.

Quality Management - **The Bureau of Quality Management and Managed Care** assumes responsibility for quality assessment and continuous quality improvement, utilization review and risk management. The Chief and staff of this Bureau chair statewide monthly meetings of RBHA QM Coordinators to recommend, review and implement standards of care and practice guidelines.

BHS has established a structure for monitoring the RBHA system. The monitoring program incorporates quality concepts and decision support systems to measure the programs and services delivered through ADHS/BHS and the RBHAs. Fundamental to the program are the RBHA Monitoring Teams. Each team is composed of BHS staff that represent all of the functional areas within BHS.

Management Information Systems - The Behavioral Health Applications Team of Information Technology Services provides automation support to BHS to achieve its business goals. Staffs' primary function is to develop and maintain the Client Information System (CIS) application and database. This system tracks clients receiving behavioral health services in Arizona. The main functions of the system are:

- Client intake/registration
- AHCCCS interface (reporting of Title XIX clients and services)
- Client service tracking
- Fund tracking and reporting
- Ad hoc reporting/BHS management reporting
- External agency reporting
- RBHA data download interface

As ADHS/BHS moves further toward integration of data systems, additional opportunities for the continued enhancement of analysis and reporting capabilities will be identified, permitting a wide range of specialized monitoring research and projects by ADHS/BHS.

In addition to the support of the CIS system, the Information Technology Support (ITS) team develops PC stand alone applications to support business needs within various BHS offices.

Resolution of disputes - The Office of Grievances and Appeals maintains a grievance system which provides for an administrative resolution of disputes for members, subcontractors, and providers or non-contracting providers, in accordance with state and federal regulations, statutes and standards. In addition to the grievance system, BHS has designated specific staff members to act as ombudspersons, advocating to resolve problems or issues raised by members or providers. The Office of Grievance and Appeals is responsible for the development of policies and procedures, management and implementation of the grievance system within BHS, and monitoring at the RBHAs.

Arizona State Hospital - BHS is also responsible for the operation of the Arizona State Hospital. The Annual Report of the Arizona State Hospital is contained as a separate report in this document.

BEHAVIORAL HEALTH SERVICES ACCOMPLISHMENTS

State Fiscal Year 1997

TOBACCO TAX PROGRAMS

Key Objectives of the Programs

During Fiscal Year 1997, The Division of Behavioral Health Services continued to fund the twenty-five programs established in Fiscal Year 1996. The key objectives of the programs were:

- Increasing quantity and quality of the services provided in the ComCare Crisis Response Network and the Southeastern Arizona Crisis System.
- Developing and providing an array of prevention services, geared to helping youth stay in school, refrain from drug use and/or re-entering the juvenile detention system.
- Providing detoxification services in the rural areas of Yuma and Page.

- Providing behavioral health services to people over the age of sixty, who would otherwise not have services available.
- Increasing employment opportunities and support services for persons with serious mental illnesses.
- Providing a mobile mental health clinic for Yuma and LaPaz Counties and providing behavioral health services, via tele-conferencing, in northern Arizona, thereby increasing access to services in remote areas.

Key Findings

The first full year of operation provided the following results:

- Both of the crisis systems funded were enhanced by having enough funding to cover the entire geographic areas. Having comprehensive coverage, both in terms of geographic area and types of services provided, added to the satisfaction rates of people served and increased the community's satisfaction with the crisis systems.
- Project PAZ, providing transition services to adjudicated youth in the Tucson area, had a significant impact on the rearrest rates of the youth in the program. The rearrest rates for the general population of youth, previously adjudicated, is 45 %, while the Project PAZ rearrest rate, is only 8.4 %.
- Providing behavioral health treatment services for youth in detention reduced negative behaviors. School attendance improved and drug and alcohol use decreased.
- Detoxification facilities are needed and utilized in rural areas. Both the Yuma and Page facilities were well utilized, at capacity, in the first year of operation.
- The usage rate of services for persons who are elderly is dependent on strong coordination efforts between behavioral health and aging services providers.
- Alternative means of providing behavioral health services, such a mobile intake vans and tele-conferencing, significantly increased the number of people receiving behavioral health services in remote areas.

ARNOLD vs. SARN EXIT CRITERIA

The Arnold vs. ADHS case is a class action lawsuit involving behavioral health services for seriously mentally ill residents of Maricopa County. The Arnold vs. ADHS case began in 1981, with a lawsuit filed in Maricopa County Superior Court alleging that the state and county had not met a statutory obligation to provide a broad and all-encompassing system of care for the seriously mentally ill. In fiscal year 1981, the State of Arizona's budget for behavioral health care was \$637,500. The court ruled in favor of the plaintiffs, represented by the Arizona Center for Law in the Public Interest (now the Arizona Center for Disability Law), and the ruling was affirmed by the Arizona Supreme Court. In 1991, the court ordered an extensive set of system improvements, called "the Blueprint," and appointed a Monitor to oversee implementation of the Blueprint.

Since the 1990-91 fiscal year, funding of services for the seriously mentally ill has increased dramatically, from less than \$55 million to approximately \$141 million, of which approximately \$40 million comes from the federal government. With the increased funding, numerous system improvements have been implemented. These include the development of a comprehensive set of rules governing mental health rights, treatment and grievances; the creation of an in-house advocacy program for clients; the unification of funding and services with the county through an intergovernmental agreement; implementation of an extensive case management system; the award of Medicaid funding for seriously mentally ill adults; development of improved licensure standards for behavioral health providers; and the implementation of a Shelter-Plus-Care program for people who are mentally ill and homeless.

The negotiation for a clear set of exit criteria for the Arnold vs. ADHS case began in February of 1994, and was concluded in February of 1995. The Joint Stipulation on Exit Criteria and Disengagement Document describes numerous activities and outcomes that ADHS must achieve in order to exit the case.

While there are numerous activities, the items with the greatest impact in terms of budget and services delivery are the following: reduction in the census of the Arizona State Hospital; relocation of class members residing in Supervisory Care Homes; the development of a Quality Management Plan; funding for the Maricopa County Crisis System; and the development of housing, and vocational services for the seriously mentally ill. Significant progress has been made on many of the requirements, but much remains to be done before BHS can request final disengagement.

DOWNSIZING OF ARIZONA STATE HOSPITAL

As a result of the Arnold vs. Sarn lawsuit, and the resultant transfer of patients from the Arizona State Hospital (ASH) to community treatment programs, the bed capacity for classmembers has been reduced. On September 1, 1997, ASH had an inpatient census of 288 patients. Sixty-three individuals who had been at ASH for more than one year as of January 1, 1995, have been discharged. However, initial experience with the first group of ASH discharges indicated a need to re-assess the transition process in order to increase each person's successful integration into the community. Due to this reassessment, the pace of ASH census reduction has slowed. The development of new community living arrangements has enabled over 80 individuals to be discharged from ASH.

During the 1996 legislative session, ADHS sought and obtained legislative changes to permit funds to flow from the ASH operating budget into community living with appropriate supports. In addition, Laws 1996, Chapter 287, established a new "Arizona State Hospital Fund" which may be used by ADHS for treatment of patients at ASH. The sources of these funds include: (1) amounts that may be charged to RBHAs for treatment of their clients at ASH, (2) monies reimbursed by the federal government under Title XIX of the Social Security Act for services provided at ASH, and (3) monies appropriated by the Legislature and matching federal monies paid to ADHS for disproportionate share payments to ASH. The latter two sources of funds will become effective in fiscal year 1997-1998. ADHS has devised a methodology for reallocating funds from ASH to the community as the census at ASH is reduced, based upon an estimated \$54,500 per year cost of treating a person at ASH.

SUPERVISORY CARE REQUIREMENTS

As of July 30, 1997, forty-eight class (Arnold vs ADHS) members have moved from supervisory care homes into alternative settings. It has been difficult to move large numbers of individuals from these homes as there is no specific funding to assist with this requirement. The RBHA for Maricopa County established a policy and procedure regarding limiting the number of class members moving into supervisory care homes. This policy has been approved by the Court Monitor for Arnold vs. ADHS. ADHS and the Maricopa County RBHA staff have been assisting the Office of Home and Community Based Licensure in monitoring conditions at supervisory care homes. As a result of this increased monitoring effort, unacceptable living conditions have been identified in some homes and class members have been moved into safer settings.

QUALITY MANAGEMENT SYSTEM REQUIREMENTS

The quality management system has been established and initial approval was given by the Court Monitor. The plan is scheduled to start in October 1997, and will require a significant investment of ADHS and RBHA resources to be successful.

CRISIS SYSTEM REQUIREMENTS

During the fiscal year 1996-1997, over \$4.3 million additional funds were used for the development of new crisis services in Maricopa County. These funds were derived from new "Tobacco Tax" revenues and a payment from Maricopa County. ADHS expects no change in the level of crisis system funding for FY 1997-1998.

SERVICE DEVELOPMENT REQUIREMENTS

ADHS continues to have an Intergovernmental Agreement with the Arizona Rehabilitation Service Administration for the provision of appropriate vocational services for persons with a Serious Mental Illness. Although the numbers of class members receiving such services has significantly improved, it has not reached the level desired. ADHS is working with RSA to determine what action may be needed. Federal funding for housing provides the majority of new housing available to class members. ADHS and the Department of Commerce have been very successful in obtaining grants for HUD funds. In the past three years the housing opportunities for the seriously mentally ill have increased from under 100 units, to over 1,100 units. One impending problem is that there may be changes in the amount of HUD funds that are available. This would seriously disrupt this important service.

BEHAVIORAL HEALTH SERVICES STRATEGIC PLANNING INITIATIVE

The Behavioral Health Services Strategic Plan represents the future direction for the ongoing development of the statewide system of behavioral health services, and establishes the philosophical and operational framework from which the Division of Behavioral Health Services (DBHS) will develop and implement behavioral health services in partnership with the Regional Behavioral Health Authorities (RBHA's) and other stakeholders.

The Division of Behavioral Health Services began a strategic planning process in March 1996. Key Directions, Principles and Goals were developed to more clearly define the roles, responsibilities, and priorities for the behavioral health system.

To obtain community wide recommendations and participation, the planning process included review and discussion of seven strategic questions in 20 communities around the State. Participants in the Community Forums included consumers, family members, and individuals representing education, juvenile justice, law enforcement, hospitals, local elected officials, Regional Behavioral Health Authorities, Tribal governments, and a variety of service providers. Additionally, the strategic questions were discussed at the state level with the Behavioral Health Services Consumer Advisory Board, the other state agencies serving children, and Department of Health Services management.

The information obtained from the Community Forum discussions is the basis on which the Behavioral Health Services Strategic Plan was revised and finalized.

During the next phase of the planning process, the Division of Behavioral Health Services is identifying performance measures to monitor progress toward the goals at the state level.

CUSTOMER SATISFACTION

BHS continued the Client Satisfaction Incentive Program for the second year. The Pinal Gila Regional Behavioral Health Authority and its providers are the pilot participants. The program is designed to provide monetary awards to all employees in each agency, based upon client satisfaction. The elements of the award are 50 percent client satisfaction, and 50 percent productivity measures.

ADHS conducted its most recent annual statewide Satisfaction Survey during the week of May 19th-23rd, 1997. Designed to assess overall satisfaction rates of persons receiving outpatient behavioral health services, the statewide process utilized a fifteen-item survey instrument which includes both demographic and satisfaction components.

Prior to the target week of the survey, the survey instrument and related materials were distributed to RBHA Quality Management (QM) Coordinators. These QM Coordinators, in turn, coordinated the distribution of the survey instrument along with an attached self-addressed stamped envelope to provider agencies engaged in the business of providing direct outpatient related services. Survey instruments were provided in both English and Spanish. To promote client confidentiality and honest responses, a self-addressed stamped envelope for subsequent return of the completed instrument to ADHS was provided.

During this most recent cycle, the survey was completed by 3,502 clients receiving services at 114 provider agencies across the State. Results of the survey were analyzed and “Overall Satisfaction” and “Overall Excellence” were calculated. “*Overall Satisfaction*” is defined as the total # of questions with the two most favorable responses divided by the # of questions. “*Overall Excellence*” is defined as the total # of questions with the most favorable response divided by the total # of questions. Overall Satisfaction rates ranged between 83-88% with a statewide average of approximately 85%. Response rates averaged 49% and ranged between a low of 43%, and a high of 73%.

RBHA	Response Rate	Overall Satisfaction	Overall Excellence
COMCARE	46%	85.0%	59.4%
CPSA	58%	86.9%	62.9%
EXCEL	55%	87.8%	67.4%
NARBHA	43%	83.6%	60.9%
PGBHA	73%	88.1%	60.9%
STATEWIDE	49%	85.2%	59.8%

Issues/Concerns

In order to maintain consistency between provider agencies and make sure we are employing sound survey methodology with geographically distant provider agencies, a more extensive written protocol is under consideration. Alternative sampling procedures are also being reviewed to assure that a random cross-sample of the client population is being included in the process. In addition, the reliability and validity of the survey questions are being reviewed and consideration given to instrument redesign and other potentially more cost effective methods for survey administrations.

SERVICES FOR AMERICAN INDIANS ON RESERVATIONS

The Arizona Department of Health Services, Division of Behavioral Health Services currently have Intergovernment Agreements (IGAs) with four Arizona Indian Tribes to provide covered behavioral health services:

Gila River Indian Community, Navajo Nation, and Pasqua Yaqui Tribe of Arizona have an IGA for both Title XIX and State Subvention Services.

Colorado River Indian Tribe has an IGA for only State Subvention Services.

Services to other Native American Indian Tribes are provided and covered by the local Regional Behavioral Health Authority (RBHA) in which the tribal reservation resides.

BUREAU ACCOMPLISHMENTS

BUREAU FOR PERSONS WITH SERIOUS MENTAL ILLNESS

Staff of the Bureau for Persons with a Serious Mental Illness provide technical assistance, oversight, and monitoring to the RBHAs in providing a continuum of community based services for persons who suffer from serious mental illness. This office has primary responsibility for the implementation of the court ordered settlement agreement, known as Exit Criteria, in the Arnold vs. ADHS lawsuit. Approximately 22,000 individuals with serious mental illness receive services throughout the state of Arizona.

Coordination With Other State Agencies

The Bureau for Persons with a Serious Mental Illness has developed Intergovernmental agreements with the Department of Economic Security, Rehabilitation Services Administration, the Department of Commerce, and the Housing and Infrastructure Development, which have been effective in significantly increasing both vocational and housing opportunities.

Grants

Comprehensive Criminal Justice Diversion Interventions

This proposal was submitted by the Arizona Department of Health Services, Division of Behavioral Health Services, Bureau for the Seriously Mentally Ill. ADHS/DBHS/BPSMI, will serve as fiscal agent, and coordinating entity. BPSMI received notice that the proposal was accepted September 1, 1997, and have begun the initial implementation of this project. The grant award was for 1.5 million dollars over a three year period. The Community Rehabilitation Division at the University of Arizona Health Sciences Center will be responsible for the implementation of the evaluation activities of the project, including design and development of information and data collection systems, subject selection and sampling strategies, data analysis, and dissemination. ComCare, Inc. and CPSA, Inc., the managed mental health care organizations for Maricopa and Pima Counties, respectively, will be responsible for continued implementation and coordination of jail diversion activities within their communities, including proposed program enhancements to be funded by this project. The *Arizona Council on Offenders with Mental Impairments* (ACOMI) will serve as an Advisory Board for this project.

In 1992, the Arizona Legislature established through public law, the *Arizona Council on Offenders with Mental Impairments*. ACOMI, a multi-faceted group offering a broad spectrum of criminal justice and human service knowledge and skills, identified and endorsed a four-tiered model of jail diversion for individuals with a serious mental illness, including those with co-occurring substance abuse disorders. This four-tiered model includes: Front End Diversion, Release from Jail with Conditions, Deferred Prosecution, and Summary Probation. All four tiers of this model have been implemented and are operating within the two largest communities of Arizona: Phoenix and Tucson. In each of these two communities, the jail diversion programs have been implemented by private, non-profit managed mental health care organizations, and regional behavioral health authorities (RBHAs), in cooperation with local law enforcement and judicial agencies. While each community

has implemented the four-tiered diversion model articulated by the ACOMI, minor programmatic differences have occurred. These differences are most pronounced in the co-location of RBHA staff within the booking facilities and the extent of involvement of these staff, as opposed to pretrial services staff, in carrying out diversion-related services. The purpose of this grant will be to conduct a systematic and a comparative assessment of the relative efficacy of this four-tiered diversion model, as implemented within these two communities.

Specifically, this project has been designed to address four primary project objectives. The first objective is to provide methodologically sound data for answering the core research questions as identified in the GFA. The second objective of this project is to design and implement an integrated information system that allows for interactive screenings and communications between and among the regional behavioral health authorities, booking and holding facilities, and the jails regarding the status and identity of program participants. The third objective of this project is to enhance the availability of RBHA staff within the local booking facilities in order to maximize the availability of pre-booking diversion opportunities. The final objective of this project is to disseminate the findings and knowledge gained about the effectiveness of this diversion program to other communities, other states, and to the field in general.

Evaluation of Housing Approaches for the Seriously Mentally Ill

We also are coordinating a grant that was submitted by the Maricopa County RBHA to study the effects of various housing approaches. This study is part of an eleven site national program that is examining these issues. The grant award is for 1 million dollars over a three year period.

Consumer Advisory Board

The Statewide Consumer Advisory Board for the Bureau for Persons with Serious Mental Illness continued to expand its role in providing recommendations and assistance to the Bureau. The twenty member Board held eleven Board meetings, and had an average attendance of fifteen members per meeting. The Board:

- formalized By-Laws and standing sub-committees;
- planned the Fourth Annual Consumer/Family Conference;
- provided recommendations about legislation;
- contracted with Behavioral Health Services to educate and train consumers about their Individual Service Plans statewide and,
- provided a quarterly newsletter to be distributed statewide. Gather any information that will educate and inform the target population.

The Consumer Advisory Board developed a quarterly newsletter to provide information to consumers and family members about the mental health system, current trends and local information. A consumer editor/coordinator was hired, four issues were printed and 600 copies per issue were distributed to all areas of the State.

Training and Conferences

The Fourth Annual Consumer/Family Member Conference was conducted on October 31, 1997. This year the Consumer Advisory Board merged with the Mental Health Association for a joint conference "Back to the Future." Describing the interruption and struggle in the lives of people because of their mental illness was the focus of the conference. Approximately 175 attended the one day session. The conference was provided at no cost and consumers, family members, and out of town participants were assisted with travel and accommodations cost. The Consumer Advisory Board provided a committee to assist with all aspects of the conference.

Individual Service Plan Training was provided to consumers using carryover funds from the CSP grant. Through the competitive bid process, three consumers were selected to provide training throughout the state, with the bulk of the training being provided in Maricopa County. It is estimated that 100 training sessions will eventually be provided to approximately 600 persons throughout the State. It is also expected that the training will be provided to the various units at the Arizona State Hospital. The Consumer Advisory Board, in conjunction with the University of Arizona, developed the training module, which has consistently received positive comments from consumers and staff.

With the cooperation of the Arizona Alliance for the Mentally Ill (AAMI), the Bureau for Persons with Serious Mental Illness assisted over 35 consumers and family members in attending additional training. The majority of the funds were used to send people to out of state meetings and conferences, including the NAMI Annual Conference, AAMI Annual Meeting, Alternatives 95 National Mental Health Consumers' Self Help Clearinghouse, the SEEDS Symposium, and the National Cultural Diversity Conference. Through these funds, Arizona was able to have a national presence at the major mental health conferences, and in, turn bring back national information to other consumers and family members in Arizona.

Vocational Rehabilitation

The development and expansion of vocational services continued to be a high priority for the Bureau for Persons with Serious Mental Illness. In the fall of 1995, the University of Arizona, ComCare and RSA, with the financial support of BHS, were awarded a demonstration grant to provide integrated, as well as expedient vocational services. The SAMHSA funding for this program is over \$900,000 for the five year period. Over 200 consumers have been interviewed and are participating in the project.

BUREAU FOR CHILDRENS' SERVICES

The mission of the Bureau of Children's Services is to support and monitor a statewide system for the delivery of comprehensive community-based behavioral health services for all of Arizona's children and adolescents.

In 1988, Arizona enacted landmark legislation mandating the development and delivery of a comprehensive continuum of coordinated behavioral health care for children. Previously these services had been provided by different agencies according to individual mandates addressing specific populations of children. A.R.S. 36-3431, et.seq. requires interdepartmental collaboration for a single system to address the behavioral health needs of all Arizona children. BHS was designated the lead agency for the development of this children's behavioral health system.

The delivery system for behavioral health services to children in Arizona continues to develop and improve. From the 1988 legislation to the implementation of the Title XIX program, BHS has engaged in an ongoing process to meet the mandates of both Title XIX and non-Title XIX programs to serve the children in a manner which is both clinically effective and cost efficient.

During the past year the Bureau of Children's Services, in partnership with other agencies that serve children, was involved in the implementation of two major projects to coordinate services to children.

Single Purchase of Care

The second year of SPOC Phase-in implementation has begun. In response to a second interagency Request For Proposals, 87 sealed new offers and over 320 renewals were accepted and approved for twenty two behavioral health services during March, 1997. Serving the needs of more than 25,000 children in Arizona, this coordinated purchase of care system was collaboratively designed for participating state agencies to use jointly when obtaining necessary treatment for their specific populations. The joint process enables the participating agencies to collaborate on new programs, services, and to collectively negotiate with providers.

One of SPOC's goals was to address the needs of behavioral health service providers who formerly had to respond to multiple requests from each agency and to keep track of multiple contracts, including billing multiple rates for these services. Under SPOC contracts, providers establish a single rate per service, and no longer have to enter into separate contracts with each agency.

The SPOC Team, consisting of one representative from each of the participating state agencies, coordinates the statewide contracting process, including local needs assessment and monitoring, through Local Teams.

Activities in SPOC Phase-in included:

- ▶ Development of standard behavioral health service specifications for the State's Taxonomy;
- ▶ Establishment of statewide training of processes for consistent review, evaluation and negotiation of offers by Local Teams, which include representation by each participating state agency.
- ▶ Development of tools, and processes for joint monitoring statewide by Local Teams, including each participating state agency, according to utilization of provider;
- ▶ Coordination of consistent statewide contract compliance review by Local Teams;
- ▶ Establishment of survey documents for providers, and other stakeholders and performance of evaluation of SPOC Phase-in, including assessing any financial impact;
- ▶ The compilation, and distribution of an annual SPOC Resource Directory which includes contract information such as services offered, rates, staff, targeted populations, agency locations, telephone, and facsimile numbers, and contact persons.

Effective July 1, 1997, over 400 SPOC contracts have been issued to providers across the state. Local Teams have reported increased communication, more shared interests, deeper understanding of their separate agencies' programs and improved networking.

Interagency Case Management Project

Interagency Case Management Projects (ICMPs) have now been fully implemented in Maricopa, and Mohave Counties. The purpose of ICMP is to centralize, coordinate, and manage the utilization of publicly administered services, and funds for state agencies serving children. The Maricopa and Mohave ICMP Projects differ in structure, but have the same key goals:

- ▶ Unduplicate case management;
- ▶ Develop an effective, efficient coordinated service delivery system;
- ▶ Demonstrate that a cooperative, collaborative effort can be achieved between state agencies;
- ▶ Ensure families and children receive appropriate and timely assessment and services;
- ▶ Improve the cost effectiveness of the service delivery system; and,
- ▶ Recommend ways to streamline administrative processes across agencies.

As of June 1997, the Maricopa County ICMP has provided multi-agency case management services to a total of 125 children. Efforts are currently underway to transfer additional children who meet ICMP eligibility criteria into the project.

Considerable progress has been made on addressing several implementation issues raised by ICMP personnel since the project began providing case management services to multi-agency children and their families in November, 1995. Major issues raised included duplicative paperwork requirements when a child's case is open to multiple agencies; numerous and duplicative case staffing requirements; and incompatible data systems maintained by each agency, precluding the development of a comprehensive database on multi-agency children, and causing duplication in data entry. Interagency subcommittees have been formed to address many of these issues, while others are being addressed by The Case Management Work Group which is responsible for ongoing implementation of the project.

Other significant accomplishments include the development of Interagency Cost-Sharing Guidelines to streamline the process of cost sharing for services between agencies, and the employment of a contracted evaluator to provide a comprehensive, multi-year evaluation of the project.

Since June, 1996, the Mohave ICMP has provided Multi-Agency Team (MAT) services to a total of 43 multi-agency children. The number of referrals to the project continues to increase steadily as school personnel and agency case managers become more familiar with the project.

During the first year of the project's implementation, the Mohave Oversight Committee focused on the following areas: ongoing training and consultation with local Multi-agency Team members to identify and resolve implementation issues; development of satisfaction surveys for project evaluation purposes; development of a draft evaluation plan for a multi-year evaluation of the project; development and refinement of quarterly reports submitted to the Case Management Work Group and IGA Executive Committee; and increasing referrals to the project through outreach to schools and local case management sites.

Staff from the Bureau of Children's Services also participated in a number of additional efforts to improve the system, including:

- ▶ Continued participation in an interagency effort to coordinate transition services for adolescents who are deaf-blind. The purpose of this project is to establish local teams to support these individuals in their efforts to more fully function with their local communities. This project also includes the involvement of staff from the Arizona School for the Deaf and Blind, DES/Division of Developmental Disabilities, DES/Vocational Rehabilitation, Arizona Department of Education Transition Services, the University of Arizona and parents. The direction of the group is to continue to focus on transition services for the deaf and blind populations.
- ▶ Continued participation in an interagency task force addressing infant mental health services. The development of a multi-disciplinary screening tool for early identification of behavioral health problems in infants and toddlers continues to be this group's primary focus.
- ▶ Completed collaboration with DES on the development of an Operations Manual to supplement the Intergovernmental Agreement between DES and ADHS.
- ▶ Collaboration with DES/DDD on improving the care of children served by the behavioral health system who are under the care and custody of DES/ACYF or are served by DDD. A process improvement team has been assembled to work on specific issues and will be making recommendations to the Executive Committee of the Children's IGA.
- ▶ Coordination and provision of training and technical assistance to Tribal RBHAs designed to assist them in performing the various duties required.

BUREAU FOR SUBSTANCE ABUSE AND GENERAL MENTAL HEALTH SERVICES

For thousands of Arizonans, substance abuse treatment offers an opportunity to reclaim their lives and rebuild families and careers shattered by alcoholism and drug dependency. Over the past 20 years, a body of evidence has established the potential of treatment to trigger positive change in the lives of users and to dramatically reduce the social and health care costs of addictive disorders. In particular, substance abuse treatment reduces street crime, restores gainful employment, reduces risk taking lifestyles, and relieves a host of public health costs associated with HIV disease, fetal substance exposure, debilitating disease, and substance related mental health problems, such as domestic violence, suicide and chronic depression.

Similarly, untreated depression and other general mental health disorders are among the most common behavioral health problems in America today. Depression alone is responsible for more missed days of work than any other health problem except heart disease. More than half of all suicides in the U.S. each year occur in adults suffering from untreated, and often undiagnosed, depression. Individuals offered short term, early stage counseling and support are less likely to become repeat consumers of mental health services.

The Bureau of Substance Abuse and General Mental Health (BSA) provides leadership, policy direction and administration for a statewide system of treatment programs and activities committed to reducing and eliminating drug, alcohol, and general mental health problems in Arizona. Through a network of community based programs and agencies, the Bureau ensures timely availability of an array of treatment services that assist individuals in overcoming addictive disorders and their related health and social consequences.

In addition to administering the statewide delivery of primary treatment services, BSA develops policy guidelines and program standards addressing the special needs of high risk populations, including women with children, injection drug users, the dually diagnosed, criminally involved users, homeless populations, Native Americans, and other ethnic minorities.

BSA also oversees funding for programs that target high risk populations or individuals with special needs, including substance abusing adolescents, and seriously mentally ill adults with addictive disorders.

There were many accomplishments of BSA in the past year in a number of areas. They are as follows:

Treatment Initiatives

BSA was awarded an \$880,000 contract from the Center for Substance Abuse Treatment to conduct a research study on the outcomes of substance abuse treatment in Arizona.

In September, 1997, negotiations and development began on an Interagency Service Agreement with the Arizona Department of Corrections to fund substance abuse treatment services to offenders on parole. This unprecedented agreement between ADC and ADHS will assure that drug and alcohol rehabilitative services are available to a population at high risk for relapse and recidivism.

Demonstration Projects

Arizona was designated as one of seven states to participate in the Methadone Treatment Quality Assurance System (MTQAS) Study funded by the National Institute on Drug Abuse and the Center for Substance Abuse Treatment. This large scale study will define and track performance indicators, including client treatment outcomes to assess how a performance based monitoring system might be designed for methadone programs nationwide.

All field studies in the Arizona Substance Abuse Treatment Needs Assessment Study were completed. AZNAS field activities included an 8,600 person Telephone Household Survey, 750 interviews with adult and juvenile arrestees, and 600 interviews with adults on three Native American reservations to determine the extent of substance use and substance abuse problems in Arizona today.

BSA participates in development and release of the Arizona Profile on Substance Abuse, an independent review of drug/alcohol prevention and treatment by the Washington, D.C. based Drug Strategies, Inc. The Profile, which made national headlines for reporting rates of methamphetamine use among Arizona youth at four times the national rate, was released in collaboration with the Governor's Office of Drug Policy and other agencies and organizations involved in substance abuse treatment and prevention in Arizona.

BSA hosts the first allstate Community Drug Epidemiology Work Group. This community based surveillance project, coordinated by the National Institute on Drug Abuse, focuses on identifying and tracking trends in the abuse of street drugs through community panels.

BSA was recognized as the BHS "Team of the Year" at the annual ADHS Employee recognition event. Former Bureau Chief Terri Goens was one of three individuals nationally awarded the Marie Nyswander Award for 1997. The "Marie" is awarded each year to individuals who make significant contributions to the field of methadone treatment.

BUREAU FOR PREVENTION

The Bureau for Prevention (BFP) was established to provide education and training to a target population of Arizonans who are at risk for developing behavioral health problems. This program area responds, in part, to legislation which established the children's funding category. Twenty percent of the children's behavioral health allocation is designated for prevention services and programming. In addition, the federal Substance Abuse Block Grant contains specific set-aside funding for prevention services.

Prevention is defined as "a process of creating conditions and circumstances within the environment that enhances the opportunities for all citizens to be healthy, productive members of the community." It is also defined as a "proactive process which empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles."

BFP staff work cooperatively with community groups to develop and deliver training on specific topics; to address statewide issues related to prevention; and to provide technical assistance in the development of new programs and services.

BFP provides leadership to the prevention field in Arizona by acting as liaison to the U.S. Center for Substance Abuse Prevention, The Southwest Prevention Center, The National Prevention Network, and the National Center for the Advancement of Prevention. State of the art prevention and technology obtained through these resources are provided to the field through consultation, technical assistance, and specialized training and seminars. The following is a summary of the accomplishments of the Bureau of Prevention.

U.S. Mexico Border Hispanic Latino Leadership Institute

BFP collaborated with the Department's Border Health Office to offer three Institutes in Douglas (12/97), Nogales (4/97), and Yuma/San Luis (1/97). Participants included individuals from both sides of the border and spawned a tremendous amount of interest. An additional Institute was held in San Luis, Sonora, Mexico as a result of Mexican participants' strong commitment to addressing substance abuse along the border.

Framework for Behavioral Health Prevention

This document was developed and published in December, 1996, to provide guidance and direction for The Regional Behavioral Health Authorities and the prevention programs within each region. Presentation of the Framework were made to staff of Behavioral Health Service, Public Health, Regional Behavioral Health Authorities and provider networks that included both treatment and prevention.

OFFICE OF THE MEDICAL DIRECTOR

The Office of the Medical Director (OMD) works closely with RBHA Medical Directors to establish guidelines for treatment services and quality of care throughout the State. The Office of the Medical Director also chairs a multi-disciplinary committee of clinicians from other State agencies, RBHAs, and providers to develop service planning guidelines for children. New guidelines completed this year include substance abuse/dependence and juvenile paraphilias for children, and schizophrenia for adults.

The Arizona Level of Functioning Assessment/Service Level Checklist (ALFA) was expanded to apply to all populations that are served by ADHS/BHS. To date, the ALFA has been used to predict need for case management services in the adult population and to screen for possible serious mental illness. Preliminary analysis of this assessment information, including functional measures and diagnoses, from the ADHS/BHS data system has shown a correlation between diagnostic category, functional level, and service utilization. The development of the analysis and reporting profile will be continued so that comparative assessment and service utilization profiles can be shared with RBHAs, providers, and other stakeholders.

OFFICE OF GRIEVANCE AND APPEALS

The ADHS/DBHS grievance and appeal system provides for the resolution of disputes initiated by behavioral health consumers, subcontractors, providers, and non-contracting providers. Disputes are initiated as a result of an adverse action or decision including, but not limited to, treatment issues, rights violations, and non-payment for services.

ADHS/DBHS maintains responsibility for the administrative oversight of the RBHA and ASH grievance and appeal system, as well as the review of cases appealed from the RBHA to DBHS. DBHS also investigates cases involving adult persons who are seriously mentally ill which involve allegations of physical and/or sexual abuse, mortality and other conditions requiring investigation that involve adult members who are seriously mentally ill.

Grievance and appeal processes are implemented in accordance with Arizona State Statute, Arizona Administrative Code, federal regulations from the Health Care Financing Administration, and the AHCCCS Mental Health Policy Manual.

During FY 1996/1997, a total of 1,088 appeals, grievances, and requests for investigation were initiated statewide. This represents an increase of 277 (34%) in complaints initiated over the prior year (FY 1995/1996). Eighty-two percent of the treatment appeals were resolved by the RBHA or DBHS. For all categories (e.g. appeals, grievances and investigations) one-hundred one (9%) of the cases were appealed to fair hearing.

Outcome - 1 % of the cases remain pending.

	<u>STATEWIDE</u>	<u>RESOLVED RBHA</u>	<u>FORWARD DBHS</u>
Appeals	789	606	85
Grievances	233	160	22 ¹
Investigations	66	22	3 ¹

Of those grievances, appeals and requests for investigation sent forward to DBHS, the following is a break-out of activity:

	<u>Resolved at DBHS</u>	
Appeals	45	
Grievances ²	52	
Investigations ³	40	
Total Resolved:	137	(Out of 189 forwarded to DBHS)
Total Forwarded from DBHS to Fair Hearing:	52	
Total Appeals forwarded from RBHA to Fair Hearing (Waived at DBHS level)	49	

Note: Compared to FY 1995/1996, treatment appeals increased from 576 to 789 in FY 1996/1997

¹DBHS conducted an additional 79 investigations.

²Includes those cases initiated at DBHS level which were not further appealed.

³Includes those cases initiated at DBHS level which were not further appealed.

INVOLVEMENT OF KEY STAKEHOLDERS

ADHS/BHS has a valuable resource in the various advisory bodies which have been established, either through state or federal mandate, to provide guidance in the planning, implementation and provision of behavioral health services. BHS provides staff support to each of the councils and their various committees.

The Arizona Behavioral Health Planning Council, established through Public Law 99-660 and its subsequent amendments, is charged with the responsibility for reviewing, monitoring and evaluating the adequacy of behavioral health services in Arizona, and serving as an advocate for adults who suffer from serious mental illness and children who are seriously emotionally disturbed, as well as individuals needing other behavioral health services. The Council consists of 30 members, representing urban and rural areas and reservations, including representation from the provider community, consumers and family members, and representatives of other state agencies.

The Children's Behavioral Health Council was established pursuant to Arizona Revised Statutes, 36-3421-22, to oversee the development of a single, comprehensive, coordinated continuum of services for children. There are 21 members of the Children's Council who are appointed by the Governor, the President of the Senate, and the Speaker of the House of Representatives. Representatives from each of the state agencies serving children is represented on the Council, which meets monthly.

In 1992, the Arizona Legislature created the Council on Offenders with Mental Impairments. This Council is charged with determining the status of offenders with mental illness, mental retardation, and developmental disabilities within the State's criminal justice system to identify the services needed by those offenders.

The BHS Assistant Director meets regularly with each of the Councils. Additionally, quarterly meetings are held with the Council Chairs to discuss issues of mutual interest and to review the planning and budgeting processes.

In addition to the involvement with these Councils, BHS also actively seeks input from, and supports, the activities of consumer and family groups. The Office for the Seriously Mentally Ill established a Consumer Advisory Board, with membership representing every county in the state, as well as the on-reservation American Indian population. The Consumer Advisory Board ensures that the voice of consumers is heard by BHS as it develops policy, plans for services, and advocates for funding from the Legislature. BHS also works closely with the Arizona Alliance for the Mentally Ill, the Alliance for the Mentally Ill of Southern Arizona, and MIKID - Mentally Ill Kids in Distress, the support group for parents of children with mental illness. BHS provides funding support for conferences to send consumers and family members to national conferences and workshops, and to produce/acquire educational materials. BHS also works with the Mental Health Association, the Northern Arizona Area Health Education Center, and other groups to co-sponsor annual conferences and institutes which are attended by both behavioral health professionals and administrators, and by families and consumers.

BHS also coordinates with, and seeks input from, the RBHAs and providers. The Assistant Director meets monthly with the RBHA Directors to discuss policy and budget issues and resolve administrative matters. The Assistant Director, the Deputy Assistant Director, and members of the Management Team meet regularly with the Association of Behavioral Health Providers and the Arizona Council of Centers for Children and Adults to ensure effective communication in matters of policy, funding, or administrative issues.

WHAT'S ON THE HORIZON FOR BEHAVIORAL HEALTH SERVICES?

One of the most exciting and positive changes taking place in the field of behavioral health services are the new treatments and medications being developed each year. These new treatments have made it possible for people to receive treatment with fewer side effects and more positive outcomes. BHS plans to continue to utilize these new treatments in the coming years and to continue to find more effective ways to deal with the personal and family issues surrounding behavioral health concerns.

During the coming year BHS will also pursue new sources of funding for populations currently unserved or under served. In particular, there is a potential for funding from the Federal Government under the State Children's Health Insurance Program. The State Children's Health Insurance Program gives states funding to create health coverage programs for children in families with incomes up to twice the federal poverty level and the program gives the states flexibility in designing the types of health coverage offered. Governor Jane D. Hull will be assembling a committee to identify benefits that will be included in Arizona's State Children's Health Insurance Program. The Arizona initiative, titled KidsCare, under the leadership of Governor Hull, has the potential to provide health care to many low income families who do not have health coverage. The State Children's Health Insurance Program, KidsCare, may afford BHS the opportunity to serve children with behavioral health problems that would otherwise not be eligible. BHS will also continue to work to increase the eligibility levels for Title XIX funding through Proposition 203. Proposition 203 would increase the eligibility level for Title XIX services to 100% of Federal Poverty Guidelines. This would allow more people to be covered with Federal funding and hence be eligible for the array of behavioral health services covered under Title XIX.

BHS will continue to implement the requirements of the Exit Criteria to bring closure to the Arnold vs ADHS law suit. BHS will continue to work with the Court Monitor and the Regional Behavioral Health Authority in Maricopa County to meet the stipulations of the lawsuit.

The newly funded Tobacco Tax programs will continue to expand services to non-Title XIX eligible persons. All of the programs funded under Tobacco Tax are operational and will continue to provide quantifiable data on the outcomes of the programs.

BHS will procure a new Regional Behavioral Health Authority (RBHA) for Maricopa County for implementation during the coming fiscal year. The extensive amount of information gathered from community groups, stakeholders, and behavioral health professionals will be utilized to develop the Request for Proposal for the new RBHA.

Through the Arizona State Hospital, BHS will continue to develop programs to house and treat persons referred under Chapter 42, Sexually Violent Predator's state statute.

ARIZONA STATE HOSPITAL
ANNUAL REPORT
FISCAL YEAR 1996 - 1997

by

Lisa S. Jones, M.D.

Medical Director

Acting Chief Executive Officer/Superintendent

October 1997

August 1997

**ARIZONA STATE HOSPITAL
ANNUAL REPORT
FISCAL YEAR 1996 - 1997**

OVERVIEW BY CHIEF EXECUTIVE OFFICER/SUPERINTENDENT

The Arizona State Hospital is a component of the statewide continuum of behavioral health services provided the residents of Arizona. As part of Behavioral Health Services, Arizona Department of Health Services, the hospital is a publicly funded facility, dedicated to the restoration and preservation of the mental health of those residents of Arizona who require state-supported inpatient hospitalization. Hospital personnel continually strive to provide state-of-the-art inpatient psychiatric and forensic care. The hospital is committed to the concept that all patients and personnel are to be treated with dignity and respect to maximize personal and professional growth.

Senior management members of the hospital and Behavioral Health Services, including hospital clinical team representatives, continually review the goals and objectives of the hospital and the hospital's role in the statewide continuum of behavioral health services. Based on this continual review, it was decided that the hospital's "Vision Statement," which provides long-range guidance for hospital personnel, and the hospital's "Mission Statement," which provides shorter-range, day-to-day operational guidance for the hospital and service providers, should be modified to more accurately reflect the current role of the hospital in the statewide continuum of behavioral health services.

ASH VISION STATEMENT
The Arizona State Hospital will meet the needs of our patients and other customers in collaboration with our community partners. We will continue to be a unique and valuable resource in the provision of specialized psychiatric treatment, rehabilitation, education and research. We will always strive to improve our performance.

ASH MISSION STATEMENT
The mission of the Arizona State Hospital is to restore and enhance the mental health of persons requiring psychiatric services in a safe, therapeutic environment.

With both the "Vision Statement" and the "Mission Statement" as the guiding principles, the Arizona State Hospital provides psychiatric hospitalization and treatment for persons presently living in the state of Arizona who meet the hospital's admission criteria. While providing evaluation and active treatment, the hospital is continually cognizant of the rights and privileges of each patient, particularly the patient's right to confidentiality and privacy.

The leadership of the hospital will continually focus on the "Vision Statement" and the "Mission Statement" to provide guidance and direction for the hospital in providing services for the residents of the state of Arizona throughout the coming fiscal year.

ORGANIZATIONAL STRUCTURE

The Arizona Department of Health Services:

The Arizona Department of Health Services (ADHS) is the state agency responsible for assessing and assuring the physical and behavioral health of all Arizonans through education, intervention, prevention, and delivery of services. ADHS is comprised of six major service units which report to the Director of the Department. Behavioral Health Services (BHS) is the largest of these service units, both in number of staff and size of budget.

Behavioral Health Services:

Behavioral Health Services (BHS) was recreated within ADHS by Arizona Revised Statutes §36-3402 et. seq., effective August 13, 1986. The intent of the Arizona State Legislature was to create permanent authority for behavioral health and to express a commitment to the importance of planning, administration, regulation, and monitoring of all facets of the state public behavioral health system. The service area has primary responsibility for administering a system of behavioral health care which is responsive, individualized, compassionate, culturally sensitive, and equally accessible.

The Arizona State Hospital Governing Body:

The Arizona State Hospital Governing Body is composed of the Medical Director of Behavioral Health Services who serves as Chairperson, an Arizona State Hospital physician, and a community representative. Although the Governing Body does not have direct supervisory responsibilities for the Chief Executive Officer/ Superintendent of the Arizona State Hospital, the Governing Body does provide overall guidance for hospital leadership.

The Arizona State Hospital Advisory Board:

The Arizona State Hospital Advisory Board, established by Arizona Revised Statutes §36-217, is composed of the thirteen members appointed by the Governor of the State of Arizona. The Board is committed to advising the Assistant Director of Behavioral Health Services and the Chief Executive Officer/Superintendent of the hospital in the development, implementation, achievement and evaluation of goals, as well as communicating special hospital or patient needs directly to the Office of the Governor.

The Advisory Board does not have direct supervisory responsibilities for the Chief Executive Officer/Superintendent of the hospital.

The Arizona State Hospital:

The hospital receives overall direction and supervision from the Chief Executive Officer/Superintendent, who directly supervises the Medical Director, the Chief Operating Officer, and the Director of Quality Resource Management. These individuals have both clinical and administrative responsibilities. Although many of the services provided are comprised of both clinical and administrative components, for clarification of presentation the hospital's services are divided into two major divisions addressing: [1] Clinical/Direct Patient Care Services, which includes a component addressing Patient Treatment Programs; and [2] Administrative/Patient Support Services.

1. Clinical/Direct Patient Care Services:

The Clinical/Direct Patient Care Services include all of the clinical services that are provided to the patients on a day-to-day basis. These include all of the direct patient care services provided, e.g. Medical Staff services, nursing services, and specialized clinical services. The Chief Executive Officer/Superintendent provides overall leadership for the hospital and is the primary liaison with Behavioral Health Services and the Arizona Department of Health Services and is responsible for ensuring quality clinical care is provided for the patients of the hospital.

The Medical Director is responsible for overseeing clinical/direct patient care services. These services comprise Medical Staff services, which includes psychiatric, medical, and specialized services; psychiatric and medical nursing services, including specialty clinics; psychology services; social work services; rehabilitation services, including occupational therapy, recreational therapy, and the Psychiatric Rehabilitation Program model; and educational services. The clinical/direct patient care services of psychiatry, medicine, nursing, psychology, social work, and education and rehabilitation are provided through patient treatment programs and treatment units which are designed to meet the needs of the patients.

The Chief Operating Officer is responsible for managing selected contracted support services, medical laboratory services, and religious services.

The Director of Quality Resource Management is responsible for the utilization management program which reviews patient admissions and continued stay to ensure cost effective and efficient care; infection control directed at controlling infections diseases; and health records services which maintains both current and discharged patient health records.

Treatment Programs:

The General Adult Program is comprised of four treatment units. Each treatment unit serves as an admission, treatment and discharge unit although patients may also be transferred from one treatment unit to another based upon their special needs. These treatment units serve the seriously mentally ill patients who have been civilly committed as a danger to self, danger to others, gravely disabled, and/or persistently and acutely disabled; those who have been placed at the hospital by guardianship; and/or the seriously mentally ill who also have special medical needs. Treatment modalities include medications and medication education, individualized therapy, therapeutic groups, interpersonal skills development, structured unit activities, leisure planning and recreational therapy. Emphasis is placed on activities of daily living since many patients suffer from coexistent organic mental disturbances.

The Forensic/Behavior Management Program is comprised of five treatment units. Each treatment unit may serve as an admission, treatment and discharge unit although patients may also be transferred from one treatment unit to another. This program serves as the treatment program for evaluation and treatment of patients who are court-ordered for pre-trial evaluation, have charges pending and are civilly committed, need treatment prior to trial, have been adjudicated Not Guilty by Reason of Insanity or Guilty Except Insane, or require other specialized forensic services. Patients with a potential for violent or dangerous behavior, patients with a high escape risk and patients with legal requirements on placement receive treatment within this program. Major treatment modalities include pharmacotherapy, psychological services and extensive assessment, psychotherapy focusing on participation with treatment, interpersonal skills development, individual services for patients requiring restoration to competency, specific discharge plans and goal development. Each treatment unit provides a secure environment for various additional therapeutic activities with limited off-unit privileges granted on an individual basis.

The Youth Services Program is comprised of one treatment unit which serves as the admission, assessment and treatment program for adolescents [ages 13 through 17] requiring approximately three to four months inpatient hospitalization treatment as a result of a substantial mental disorder. Major treatment modalities include individual and group therapy, group and family therapy, academic programs, occupational and recreational therapy, and psychotropic medications, as appropriate. Aftercare planning and placement of the patient is an essential component of treatment; active liaison between the hospital and community providers occurs to assist outpatient service providers in placement and treatment referrals.

In all of the treatment programs, the results of the patient's clinical evaluations, the patient's acuity level, and the patient's legal status at the time of admission provide the multi-disciplinary clinical team guidance in determining the patient's least restrictive and most appropriate level of placement within the hospital. Throughout the patient's hospitalization, the multi-disciplinary clinical team reviews the patient's legal status and reviews and revises the patient's individualized treatment and discharge plan to ensure appropriate treatment and placement continue.

On all of the treatment units a patient's treatment is directed by a multi-disciplinary clinical team which includes the patient, hospital personnel, the patient's family and/or representative, and appropriate community behavioral health system service providers. This clinical team is responsible for completing the evaluations and developing a comprehensive, individualized treatment and discharge plan that addresses biological, psychological, spiritual and socio-economical issues to meet the patient's personal needs. The patient's psychiatrist, who provides leadership for the clinical team, is responsible for coordinating the patient's care, as well as ensuring a coordinated, well-defined patient treatment and discharge plan.

Throughout a patient's treatment, the hospital advocates placing the patient in the least restrictive and most appropriate therapeutic treatment environment. Patient placement within the hospital is made after assessment, consideration of all treatment factors, and discussion with the appropriate community behavioral health system service providers to assure the chosen placement provides maximum therapeutic benefit. The hospital is continually cognizant of its responsibilities to patients and the community.

In order to provide quality care for the patients, hospital personnel actively participate in the state-wide continuum of behavioral health care, coordinate the development of the patients' treatment and discharge plans with the patients and the appropriate community behavioral health system service providers, and encourage patient placement in alternative community programs in accordance with the individual service plan developed with the community service providers as soon as the patient is adequately prepared for placement.

The hospital implemented a Psychiatric Rehabilitation Program model which stresses education, increased self-reliance, and instrumental life skills. The program provides psychiatric patients with skills and environmental supports necessary to cope with the demands of daily living and focuses on the assumption that patients can profit from services stressing their strengths, involvement in goal-setting, and the use of active teaching techniques that generalize to community life settings. Interventions are used which focus on attainable goals, rewarding patient strengths and remediating deficit behaviors. Patient groups are conducted in various content areas such as:

- ◆ Symptom management module - designed to help patients disabled by a chronic mental illness like schizophrenia become more self reliant in managing their psychiatric symptoms. Major components include identifying warning signs of relapse; managing warning signs; coping with persistent symptoms; and avoiding alcohol and street drugs.
- ◆ Medication management module - designed to help patients disabled by a chronic mental illness become progressively more self-reliant in their use of antipsychotic medication. Major components include obtaining information about antipsychotic medication; knowing correct self-administration and evaluation of medication; identifying side effects of medications; and negotiating medication issues with health care providers.
- ◆ Basic conversation skills module - designed to provide the patient with the tools to teach participants the basic skills needed to start friendly conversations, keep them going, and end them pleasantly. Major components include verbal and non-verbal communication behaviors; starting a friendly conversation; keeping a friendly conversation going; ending a conversation pleasantly; and putting it all together.
- ◆ Recreation for leisure module - designed to help a wide range of people in all age groups become more self-reliant and resourceful in the use of their leisure time. Major components include identifying benefits of recreational activities; getting information about recreational activities; finding out what is needed for a recreational activity; and evaluating and maintaining a recreational activity.

2. Administrative/Patient Support Services:

The Administrative/Patient Support Services include a myriad of functions, ranging from the day-to-day operations of the hospital, the replacement of automation systems, and the long-range planning for hospital reconstruction. The Chief Executive Officer/Superintendent provides overall administrative leadership and direction for the hospital and is the primary liaison with Behavioral Health Services and the Arizona Department of Health Services.

The Medical Director must ensure the patient's legal rights related to the court commitment process are upheld. Patients are admitted to the hospital for court ordered treatment which is time limited; therefore, each patient's court order must be monitored carefully to ensure that an individual patient's legal rights are not violated. Additionally, the Medical Director is responsible for ensuring the Medical Staff members complete related administrative functions.

The Chief Operating Officer is responsible for managing the majority of administrative/patient support services. These services include business support services, both hospital fiscal management and patient finance; personnel services; dietary, environmental and laundry services; telecommunication services; and security services, a very crucial component since the patients are court ordered for treatment. The Chief Operating Officer has the primary responsibility for the day-to-day operations of the hospital.

The Director of Quality Resource Management is responsible for many administrative/patient support services that overlap between clinical and administrative services. These services include performance improvement, which evaluates both clinical and administrative services to implement improvement activities; risk management, which identifies and implements action to reduce potential risk; hospital information services, which maintains the patient demographic and clinical computerized databases; safety management, which coordinates compliance with required safety standards; and contract monitoring. The Director of Quality Resource Management also has the primary responsibility for coordinating the replacement and upgrading of the hospital's total information system.

PATIENT DEMOGRAPHICS and STATISTICAL SUMMATION

The Arizona State Hospital began this fiscal year on July 1, 1996, with a patient census of 372. Throughout the fiscal year, the hospital admitted 335 patients, discharged 402 patients, and ended the fiscal year June 30, 1997, with a census of 305, a net decrease of 67 patients. The average daily census for the fiscal year was 315, a decrease of 107 compared to the previous fiscal year. These patients accounted for a total of 115,059 patient days, a decrease of 39,503 days compared to the previous fiscal year.

The patient end of month census covering July, 1995, through June, 1997, is depicted in Exhibit #1. The data supporting Exhibit #1 are presented in the table on the following page.

End of Month Census Data							
Fiscal Year 1995-96				Fiscal Year 1996-97			
July	460	Jan.	407	July	358	Jan.	290
Aug.	434	Feb.	401	Aug.	335	Feb.	295
Sept.	437	Mar.	405	Sept.	339	Mar.	286
Oct.	452	Apr.	394	Oct.	319	Apr.	300
Nov.	438	May	388	Nov.	316	May	296
Dec.	428	June	372	Dec.	301	June	305

A comparison of monthly admissions to and discharges from the hospital is presented in Exhibit #2.

EXHIBIT #1

END OF MONTH CENSUS

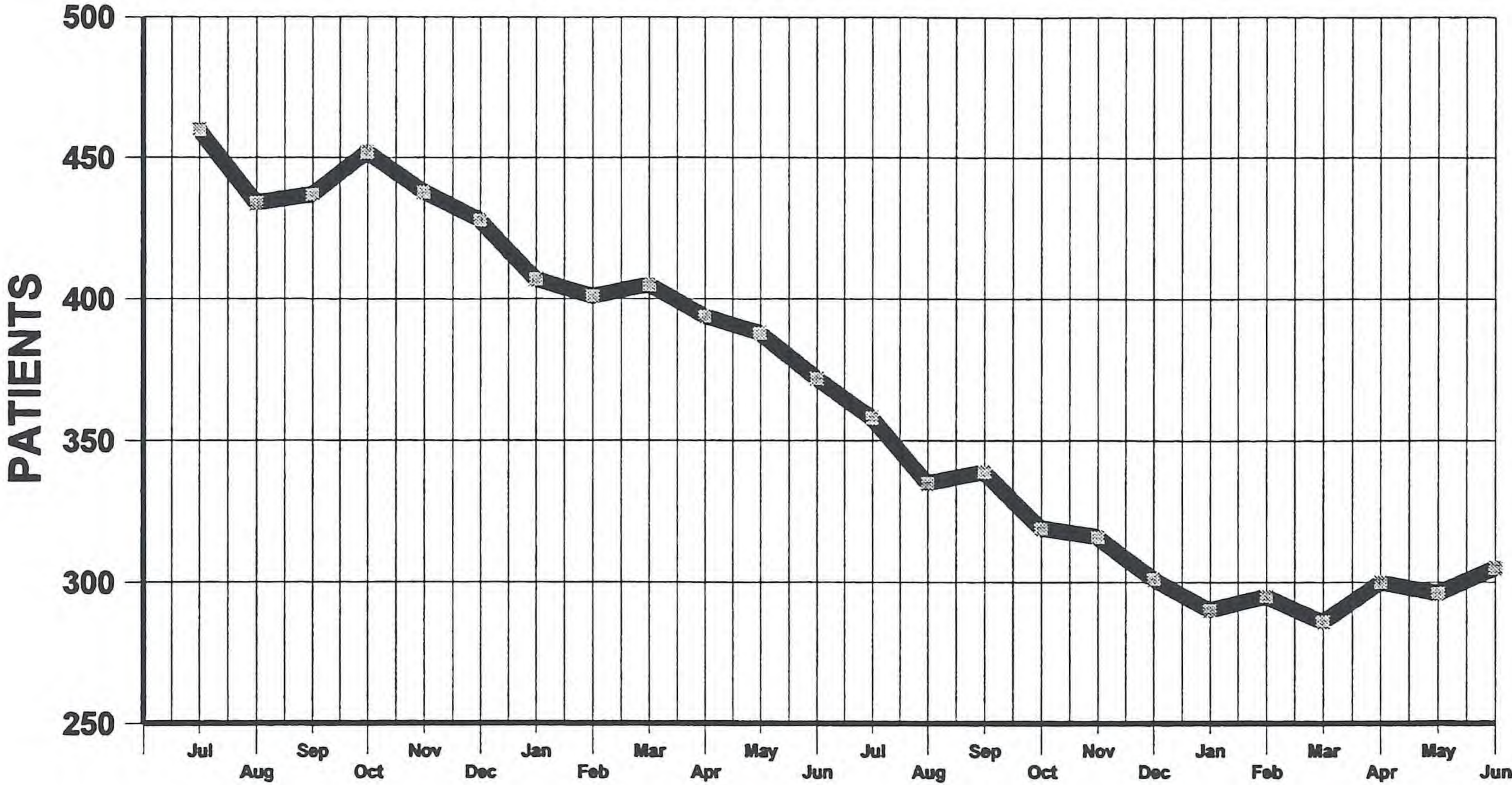
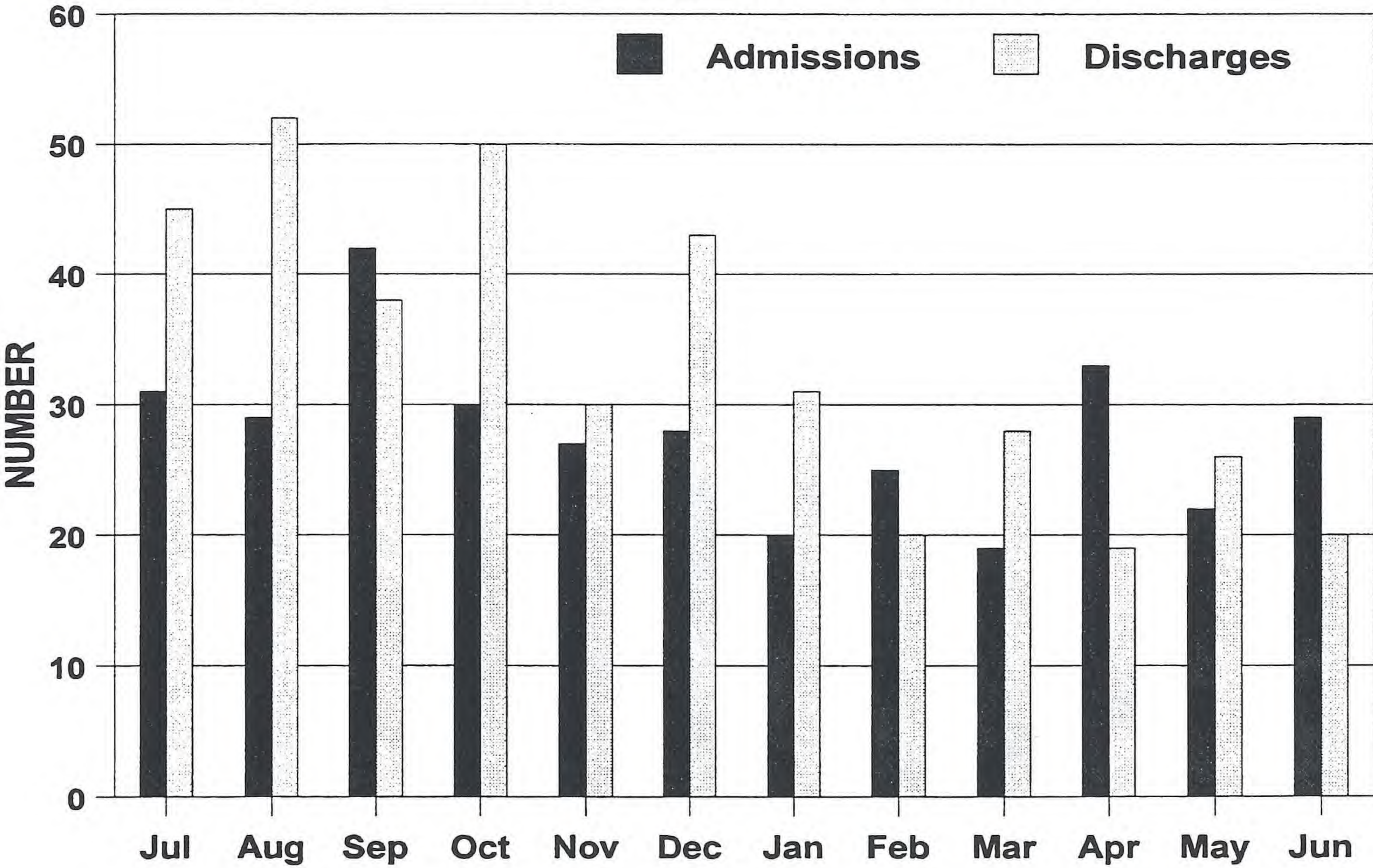


EXHIBIT #2

MONTHLY ADMISSIONS AND DISCHARGES



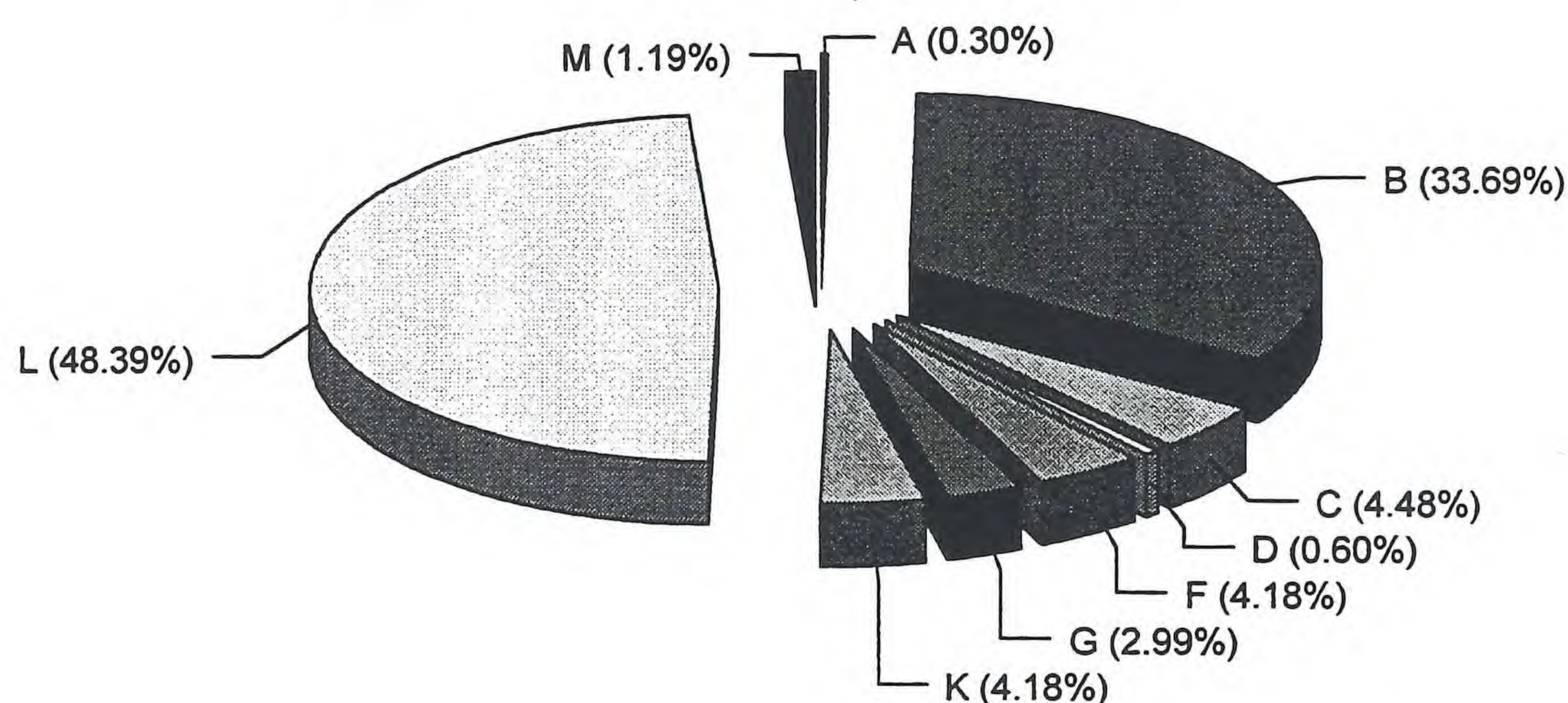
Admi	31	29	42	30	27	28	20	25	19	33	22	29
Disc	45	52	38	50	30	43	31	20	28	19	26	20

Admission Statistics:

The hospital admitted 335 patients this fiscal year, a decrease of 142 compared to the previous fiscal year. The average monthly admission rate was 27.9, ranging from a high of 42 in September, 1996, to a low of 19 in March, 1997 [Exhibit #2]. Of the total admissions, involuntary admissions accounted for 320; admission by guardian accounted for 14; and voluntary admissions accounted for only 1. Of the 320 involuntarily admissions, 162 were admitted under Title 13, Restoration to Competency; 113 were admitted under Title 36, Court Ordered Treatment; 15 were admitted under Title 8, Juvenile Commitment; 14 were admitted under Title 13, Guilty Except Insane; 10 were admitted under Title 13, Not Guilty by Reason of Insanity; 4 were admitted under Title 13, Observation; and 2 were admitted under Transfer of Prisoner. [Exhibit #3].

Legal Status at Admission			
Code	Legal Status	Number	Percentage
A	Voluntary	1	0.30
B	Court Ordered Treatment	113	33.69
C	Juvenile Commitment	15	4.48
D	Transfer of Prisoner	2	0.60
F	Title 36, Placement by Guardian	14	4.18
G	Title 13, Not Guilty by Reason of Insanity	10	2.99
K	Title 13, Guilty Except Insane	14	4.18
L	Title 13, Restoration to Competency	162	48.39
M	Title 13, Observation	4	1.19

EXHIBIT #3 LEGAL STATUS AT ADMISSION



Maricopa County continued the historic trend of having the highest number of admissions by county with 149, but decreased admissions by 114 compared to the previous fiscal year; this is the first fiscal year that Maricopa County did not account for more than 50% of the admissions. Pima County accounted for 89 of the admissions, a decrease of 14 compared to the previous fiscal year; and Yavapai County accounted for 19, an decrease of 8 compared to the previous fiscal year. It should be noted that not all patients admitted through a county are actually a resident of the admitting county but may be, in fact, a resident of another county, i.e. there were 13 admissions of individuals who were not residents of the counties through which they were admitted. [Exhibit #4].

EXHIBIT #4 ADMISSIONS BY COUNTY		
County of Admission	Number	Percent of Total Admission
Apache	3	.9
Cochise	12	3.6
Coconino	7	2.1
Gila	8	2.4
Graham	7	2.1
Greenlee	1	.3
LaPaz	1	.3
Maricopa	149	44.5
Mohave	9	2.7
Navajo	6	1.8
Pima	89	26.6
Pinal	15	4.5
Santa Cruz	2	.6
Yavapai	19	5.7
Yuma	7	2.1
Total	335	[100]
Number of admissions through a county in which the individual was not a resident [total =13]:		
Apache 0	Greenlee 0	Pima 5
Cochise 1	LaPaz 0	Pinal 1
Coconino 0	Maricopa 2	Santa Cruz 0
Gila 1	Mohave 0	Yavapai 2
Graham 0	Navajo 1	Yuma 0

The hospital's recidivism rate for Fiscal Year '97 was 8.4%, a decrease of 7.1% compared to Fiscal Year '96 and a decrease of 12.3% compared to Fiscal Year '95.¹ Recidivism is defined as the readmission of a patient who was discharged from the hospital within 180 days prior to readmission. The significant decrease in the recidivism rate is indicative of the continuing joint efforts by Behavioral Health Services, the Regional Behavioral Health Authorities, and the hospital to seek alternatives to readmission of patients requiring short-term interventions.

Individuals admitted to the hospital for the first time accounted for 222 (66%) of all admissions, an increase of 12%. This increase is attributed to individuals admitted with a forensic legal status to the hospital for the first time [149 in Fiscal Year '97, 103 in Fiscal Year '96, and 32 in Fiscal Year '95].

¹The recidivism rates presented are determined by dividing all of the fiscal year readmissions with lengths of stay out of the hospital less than 180 days by the total admissions for the fiscal year.

Readmissions from a previous discharge accounted for 99 (30%), readmissions from conditional discharge accounted for 8 (2%), readmission from combined inpatient/outpatient treatment accounted for 4 (1%), and Return from AWOL Status accounted for 2 (<1%).

Admissions by diagnostic grouping (patient diagnosis at the time of admission) indicate the category of schizophrenic disorders accounted for 139 (41%) of all admissions and affective disorders accounted for 67 (20%). These two diagnostic categories have continued to be the major diagnostic groupings for patient admissions.

Discharge Statistics:

The hospital discharged 402 patients during this fiscal year. The average monthly discharge rate was 33.5, ranging from a high of 52 in August, 1996 to a low of 19 in April, 1997 [Exhibit #2].

Exhibit #5 provides detailed data for discharge length of stay for patients with a non-forensic legal status, discharge length of stay for patients with a forensic legal status, and a total discharge length of stay for all patients during Fiscal Year '97.

EXHIBIT #5						
DISCHARGE LENGTH OF STAY						
Length of Stay for Discharge	Non-Forensic		Forensic		Total	
	#	%	#	%	#	%
Less than 90 days	54	22	71	45	125	31
90 - 180	63	26	68	43	131	33
181 - 365	39	16	13	8	52	13
366 - 1095	61	25	5	3	66	16
1096 - 2190	19	8	0	0	19	5
2191 - 3650	4	2	0	0	4	1
Greater or equal to 3650 days	5	2	0	0	5	1
Totals	245	[100]	157	[100]	402	[100]

Since the forensic patient census of the hospital is increasing while the general adult population is decreasing, the presentation of patient discharge data in Exhibit #5 has been divided into non-forensic, forensic, and total data while the data in Exhibit #6 presents only total data. Exhibit #5 and Exhibit #6 provide the following information related to patient discharges:

- ◆ Of the total 245 non-forensic patients discharged, 117 or 48% had a discharge length of stay less than 180 days.
- ◆ Of the 157 forensic patients discharged, 139 or 88% had a discharge length of stay less than 180 days.

- ◆ The total number of patients discharged with a length of stay less than 180 days was 256 or 64% of the total patients discharged. This data continues to support the premise that the hospital, Behavioral Health Services, and the Regional Behavioral Health Authorities are committed to the concept that patients are to be admitted to the hospital for intensive treatments and shorter durations rather than extended treatments and extended hospitalization periods.
- ◆ The number of patients discharged with a length of stay greater than three years but less than six years was 19, approximately the same as the previous fiscal year.
- ◆ Of the total 245 non-forensic patients discharged, 23 or 10% had a discharge length of stay of more than three but less than ten years. These patients are very often difficult to place in community settings and require extensive coordination between the hospital and the community services providers who will provide follow-up services.
- ◆ The mean length of stay for the five discharged patients with lengths of stay greater than ten years was 6,108 days, approximately sixteen and one-half years.

EXHIBIT #6 MEAN DISCHARGE LENGTH OF STAY		
Length of Stay	Total Discharged	Mean
Less than 1 year	308	121 days
More than 1 year but less than 3 years	66	647 days
More than 3 years but less than 6 years	19	1469 days
More than 6 years but less than 10 years	4	2749 days
More than 10 years	5	6108 days
Total Average Length of Stay	N/A	371 days
Note: The mean discharge length of stay is the average number of days of hospitalization per patient during that time period.		

Patients discharged back to the courts accounted for 130 (32%) of the total discharges; those discharged to the outpatient portion of a combined inpatient/outpatient commitment accounted for 85 (21%); those discharged to voluntary status accounted for 46 (11%); those discharged under Title 36 Placement by Guardian accounted for 37 (9%); those discharged under conditional discharge accounted for 36 (9%); and those discharged from a juvenile commitment accounted for 25 (6%). These discharge categories accounted for 359 (89%) of the 402 total discharges.

MAJOR OCCURRENCES

Throughout Fiscal Year 1997 the trend toward providing increased psychiatric care and treatment for forensic patients continued. This was clearly evidenced by the fact that of the total admissions to the hospital (335), forensic patients accounted for 192 (57%) of these admissions. This phenomenon has been a carefully designed and planned transition as the community service providers have increased services to provide improved and expanded mental health services in the community. In Fiscal Year '92, the concept of "right-sizing" the hospital census was developed as a result of strategic planning by management teams of the hospital and Behavioral Health Services. These planning efforts resulted in the identification of special hospital services not provided through community behavioral health settings and the number of patient beds that would be required to provide those services. Although the initial projection was that the hospital could reduce the total patient census to 250, continuous strategic planning efforts by the management teams of the hospital and Behavioral Health Services have resulted in a projected need of 315-330 licensed beds at the hospital.

The increasing forensic/behavior management population, coupled with the decreasing general adult population, has necessitated the hospital develop new programs and undergo continuous treatment program and unit review to ensure adequate capacity for the ever-changing patient census. Additionally, the hospital has continued to increase specialized forensic training and education for non-Medical Staff personnel, to improve patient programs, and to increase community mental health service providers participation in patient discharge planning in an effort to decrease the patient length of stay.

Prior to the beginning of Fiscal Year '97, the hospital began extensive preparation for a full survey by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In September, 1996, the JCAHO full survey was completed and the hospital received full accreditation with commendation, an accomplishment achieved by less than one percent of the total hospitals surveyed.

At the beginning of September 1997 the total hospital patient census had been reduced to 335. As a result of the reduced hospital census, the first phase of a "reduction-in-force" was implemented. The patient census continued to decline and by the end of November 1997 the patient census had declined to 316. With the anticipation that the patient census would continue to decline, a second phase of the "reduction-in-force" was implemented in early December 1997. This second phase of the "reduction-in-force" resulted in the hospital being significantly understaffed. In mid-December 1997 a Health Care Financing Administration Medicare Certification survey team completed a Medicare compliance survey with the results indicating the hospital was no longer in compliance with Medicare standards due to inadequate staffing patterns, lack of active patient treatment, and insufficient patient health record documentation of active treatment.

An extensive plan of correction was implemented to alleviate the noted deficiencies but limited time constraints did not permit full implementation of the corrective actions. In March 1997 the Health Care Financing Administration Medicare Certification survey team completed a follow-up compliance survey which resulted in the same findings as the initial survey. Subsequently, in April 1997 the hospital voluntarily withdrew from participation in Medicare reimbursement with the plan to re-apply for re-certification by late 1997.

Also in April 1997, as a result of the Health Care Financing Administration Medicare Certification survey team findings, the Joint Commission on Accreditation of Healthcare Organizations completed an unannounced survey. Based on the findings of this unannounced survey, hospital's status with the Joint Commission was modified from "accreditation with commendation" to "accreditation contingent upon compliance with type in recommendations" for deficiencies related to Patient Rights [inadequate staffing and safety issues] and Human Resource Planning [inadequate staffing].

The hospital continued to aggressively implement the plans of corrective action to address the deficiencies noted by both the Health Care Financing Administration Medicare Certification survey team findings and the Joint Commission on Accreditation of Healthcare Organizations findings but as of the end of Fiscal Year '97, the deficiencies cited by the surveying organizations remain.

A final major occurrence impacting the hospital occurred in June, 1997. Arizona Revised Statute §13-4603, which became effective July 1, 1996, requires persons categorized as "sexually violent persons" to be committed to the state hospital until such time as they are determined to no longer be a threat to public safety. On June 23, 1997, the U.S. Supreme Court upheld the Kansas state law establishing civil commitment procedures for "sexually violent persons" who have completed their prison sentences. Since the Arizona law is virtually identical to the Kansas law, during Fiscal Year 1998 some of the sexually violent persons who have completed their prison sentences will be committed to a separately licensed unit operated under the supervision of the hospital's Chief Executive Officer. Hospital, Behavioral Health Services, and Department of Health Services senior administrative and clinical personnel have initiated planning efforts which address appropriate housing and treatment efforts for the sexually violent persons.

STRATEGIC PLANNING AND THE FUTURE OUTLOOK FOR THE HOSPITAL

Based on the major occurrences significantly impacting the hospital during Fiscal Year '97, senior management members of the hospital and Behavioral Health Services, including hospital senior clinical team members and other hospital administrative representatives, reviewed the goals and objectives of the hospital and the hospital's role in the statewide continuum of behavioral health services. Based on this deliberation, revised goals and objectives were drafted. These draft goals and objectives were presented extensively to hospital personnel, community stakeholders, and advisory groups to receive their input. Each comment received was carefully reviewed and considered for inclusion into the final goals and objectives.

Prior to completing the strategic planning process, a final review of the plan was completed by the hospital's senior management, the Assistant Director of Behavioral Health Services, the hospital's Governing Body Chairperson, and the Office of Strategic Planning and Budgeting, ADHS. The hospital's goals and objectives were finalized as follows:

- GOAL 1. The Arizona State Hospital will improve patient and customer services.**
- Objective 1. To improve patient treatment by providing increased individualized active therapy by November 1, 1997.
 - Objective 2. To improve patient treatment by providing increased therapeutic and education activities by January 1, 1998.
 - Objective 3. To improve external customer relations, including the Arizona Department of Health Services, Behavioral Health Services, and Regional Behavioral Health Authorities, by facilitating ongoing communication related to shared goals.
 - Objective 4. To monitor external contractors' performance to ensure food, housekeeping, maintenance, and grounds keeping services meet the treatment unit needs in a timely manner by October 1, 1997, and ongoing.
 - Objective 5. To implement a multi-disciplinary assessment tool on all patient treatment units by January 1, 1998.
- GOAL 2. The Arizona State Hospital will have a staffing pattern that meets the patients' needs based on patient acuity.**
- Objective 1. To define the hospital's required staffing pattern and appropriate mix based on program needs, patient acuity, and treatment goals by August 1, 1997.
 - Objective 2. To continually adjust the hospital's staffing pattern based on program needs, patient acuity, and treatment goals.
 - Objective 3. To regain and maintain HCFA Medicare certification by January 1, 1998.
 - Objective 4: To remove the Joint Commission on Accreditation of Healthcare Organizations [JCAHO] Type in deficiencies by January 1, 1998.
 - Objective 5: To reduce the staff vacancy rate to 5% or less by January 1, 1998.
- GOAL 3. The Arizona State Hospital will develop and implement an integrated automation system.**
- Objective 1. To identify and implement a hospital automation system that has the capability of being expanded to meet the needs of the hospital by January 1, 1999.
 - Objective 2. To implement the new automation system by January 1, 1999.
- GOAL 4. The Arizona State Hospital buildings and grounds will meet the needs of current and future patients, families, and staff.**
- Objective 1. To improve the safety and security of buildings and grounds by July 1, 1998.
 - Objective 2. To improve the adequacy and appropriateness of patient buildings by July 1, 1998.
 - Objective 3. To improve the attractiveness and appropriateness of grounds in all areas of hospital by July 1, 1998.

GOAL 5.

The Arizona State Hospital will establish a program for violent sexual persons.

- Objective 1. To identify the housing location for violent sexual predator program by October 1, 1997.
- Objective 2. To develop a treatment program for the violent sexual predator program by October 1, 1997.
- Objective 3. To develop an appropriate staff-to-patient ratio for the violent sexual predator program by October 1, 1997.
- Objective 4. To seek and obtain appropriate budgetary allocation for the program for violent sexual predators by October 1, 1997.

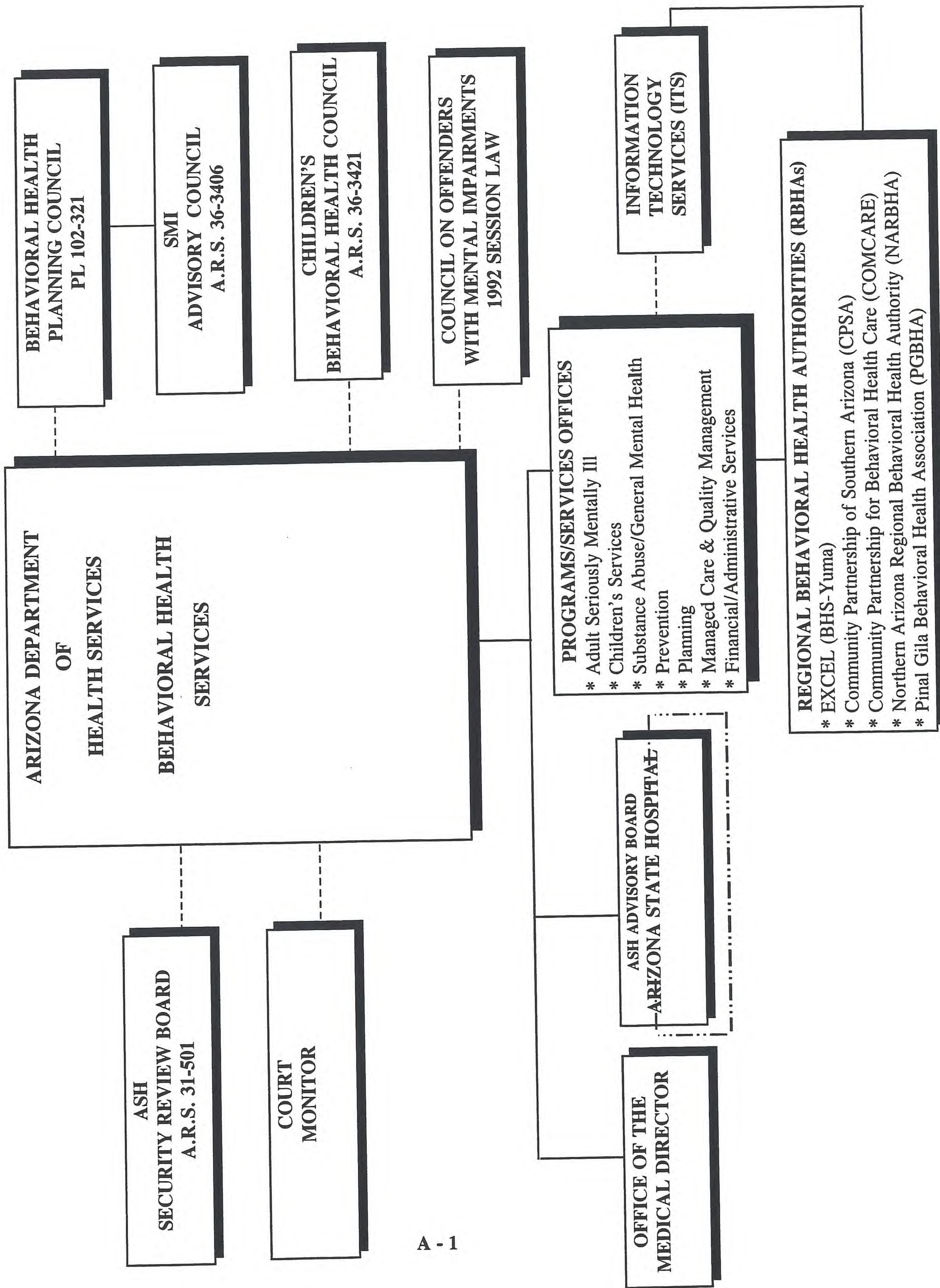
The Arizona State Hospital continues to be a dynamic service, ever-changing to meet the needs of mentally ill individuals who require inpatient treatment and services.

Throughout Fiscal Year 98, the hospital will continue its efforts to attain each goal and to address the special issues impacting the future outlook of the hospital. The hospital is firmly committed to the "ASH Vision Statement" and the "ASH Mission Statement." Each will provide direction and a reaffirmed commitment for all hospital staff throughout Fiscal Year 98.

With continued support from Behavioral Health Services, the Arizona Department of Health Services, the mental health advocacy groups, the hospital's Advisory Board, the Governor's Office, the State Legislature, and the citizens, the Arizona State Hospital will continue to restore and enhance the quality of life and health of persons with mental illness, advocate for the special needs of the mentally ill, and meet the needs of the mentally ill patients of the State of Arizona.

APPENDIX A

ORGANIZATIONAL STRUCTURE



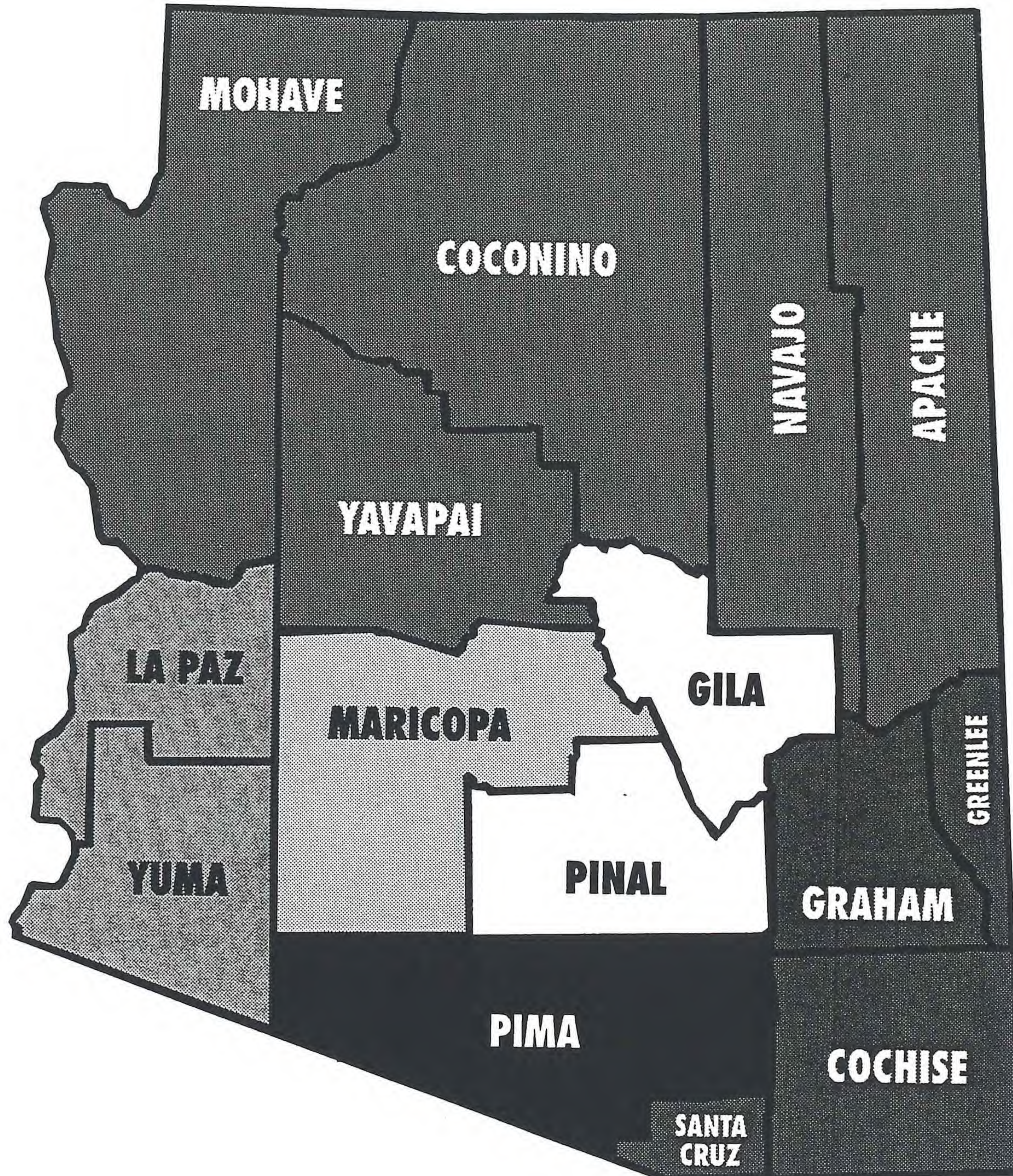
APPENDIX B

ARIZONA DEPARTMENT OF HEALTH SERVICES

DIVISION OF BEHAVIORAL HEALTH SERVICES

REGIONAL BEHAVIORAL HEALTH AUTHORITIES

GEOGRAPHIC SERVICE AREAS



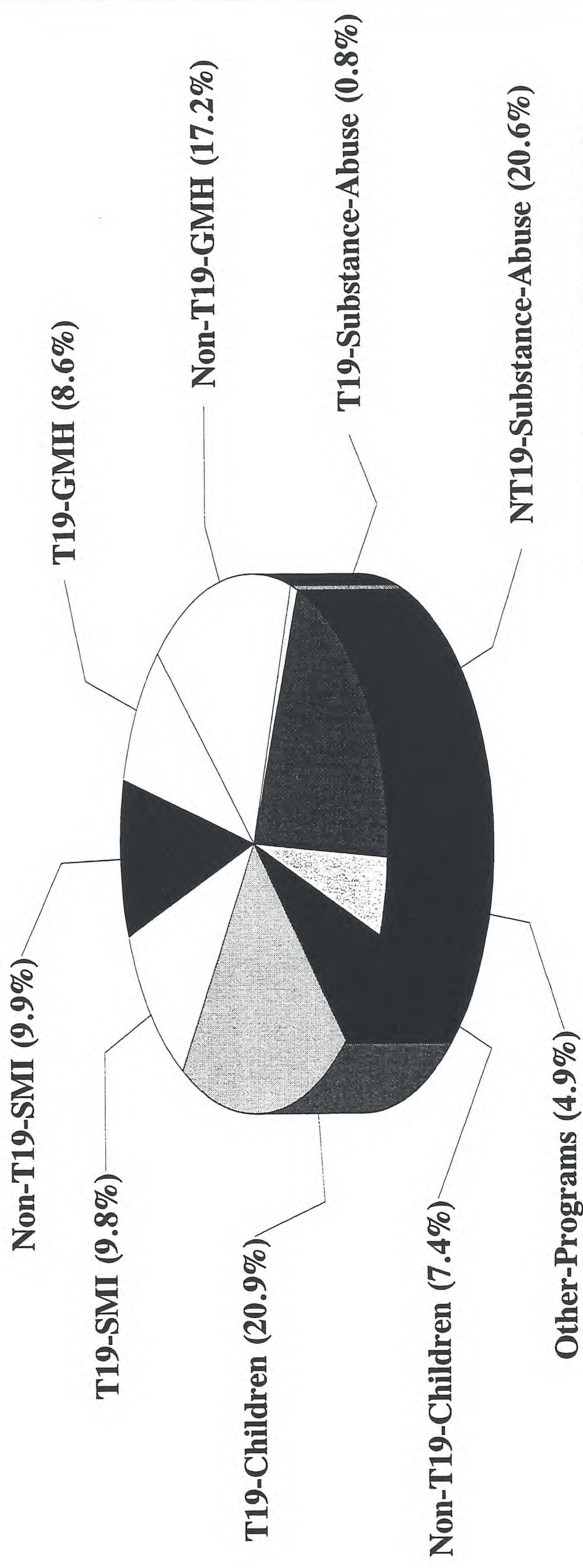
REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA)	MAP KEY
CPSA-05	
BHS-YUMA	
COMCARE	
NARBHA	
PGBHA	
CPSA-03	

APPENDIX C

ADHS/BHS Client Information System

Clients Served by Program Statewide

As of 10/1/97 - For 7/1/96 Through 6/30/97



Other-Programs (4.9%)	5,575
NT19-Substance-Abuse (20.6%)	23,530
T19-Substance-Abuse (0.8%)	933
Non-T19-GMH (17.2%)	19,604
T19-GMH (8.6%)	9,812
Non-T19-SMI (9.9%)	11,306
T19-SMI (9.8%)	11,180
T19-Children (20.9%)	23,835
Non-T19-Children (7.4%)	8,481

ADHS/BHS Client Information System Clients Served Report FOR 7/1/96 THROUGH 6/30/97 AS OF 10/1/97

BY RBHA

CHILDREN

SMI

NON-SMI

T19	Non T19	Children ¹ Subtotal
467	243	710
14263	4864	19127
2383	1151	3534
1724	890	2614
4165	963	5128
977	387	1364
23979	8498	32477

T19	Non T19	SMI Subtotal
288	327	615
6886	6807	13693
1078	1126	2204
527	422	949
2019	2308	4327
486	416	902
11284	11406	22690

GMH T19	GMH Non T19	Alcohol T19	Alcohol Non-T19	Drug T19	Drug Non T19	Other Programs	Non-SMI Subtotal	Unduplicated RBHA Total
227	522	14	268	8	253	158	1450	2746
5775	12334	324	5717	233	9470	3450	37303	68525
1257	2123	29	906	73	1527	604	6519	11989
591	1032	4	451	12	721	334	3145	6608
1611	3222	118	1289	76	2416	780	9512	18576
398	426	9	227	33	367	264	1724	3930
9859	19659	498	8858	435	14754	5590	59653	112374

TOTAL

STATEWIDE

CHILDREN

SMI

NON-SMI

T19	Non T19	Children ¹ Subtotal
23835	8481	32316

T19	Non T19	SMI Subtotal
11180	11306	22486

GMH T19	GMH Non T19	Alcohol T19	Alcohol Non-T19	Drug T19	Drug Non T19	Other Programs	Non-SMI Subtotal	Unduplicated RBHA Total
9812	19604	498	8841	435	14689	5575	59454	111616

STATEWIDE²

¹The subtotal columns may contain duplicated counts due to clients changing programs during the reporting period.

²The STATEWIDE statistics represent unduplicated counts at the statewide level, and may not equate to the summing of the RBHA statistics. Summing across RBHAs can cause duplicated counts due to clients transferring RBHAs.

APPENDIX D

**ARIZONA STATE HOSPITAL
FINANCIAL SUMMARY
FISCAL YEAR 1996 - 1997**

Funding Sources (General Operations Based on Budget Allocations):

Personnel Services and Related Benefits - General Fund	\$ 8,306,373
All Other Operating - General Fund	4,027,550
Disproportionate Funds	11,993,900
Non-Title 36 Revenue	348,515
Rental Income	630,863
Endowment Earnings	700,824
Patient Benefit Fund	109,207
Community Placement (Title XIX)	1,500,000
Donations	29,259
Grants	12,000
Community Placement (Non-Title XIX)	4,880,000
Psychotropic Medications	63,500
Total Funding	\$32,601,991

Expenditures:

Personnel Services and Related Benefits	\$15,924,725
Professional and Outside Services*	6,207,600
Travel (In-State)	24,956
Travel (Out-of-State)	3,998
Food	-0-
Other Operating	2,672,627
Capital Equipment	34,493
Assistance to Others	5,545,535
Total Cost of Operations	\$30,413,934

Collections (Deposited to the General Fund):

Medicare	\$ 656,706
Family, Guardian, or Patient	385,322
Insurance	182,843
Social Security, V.A., or Railroad Retirement	153,164
Total General Fund Collections	\$ 1,378,035

* Contract Physicians, Outside Hospitalization Costs, Outside Medical Services, and privatization of Support Services

Daily Costs by Treatment Program:**

General Adult Program	\$285
Behavior Management Program	257
Youth Services Program - Adolescent Treatment	563
Average	\$286

** Rates became effective 12/01/96.

Annual Report of Source and Use of Funds

For Fiscal Year Ending June 30, 1997

CHILDREN

	Balance Carried Forward From FY 1996	FY 1997 Revenues	Transfers In	Transfers Out	FY 1997 Expenditures	Reverted To FY 1997	Balance Carried Forward To FY 1998
Non-General Fund Receipts	\$99.4	\$1,649.9			\$1,716.3		\$33.0
Federal Funds	(109.6)	3,144.0			3,281.8		(247.4)
Title XIX Federal Passthrough	161.6	33,021.4			33,175.6		7.5
General Appropriations		142.5			142.5		
Special Line Item Funds (Non-Reverting)		37,726.2			36,084.5	1,641.7	
Special Line Item Funds	\$151.4	\$75,684.0			\$74,400.6	\$1,641.7	(\$206.9)

ADHS/DBHS Administrative Costs

	Non-General Fund Receipts	Federal Funds	Title XIX Federal Passthrough	General Appropriations	Special Line Item Funds (Non-Reverting)	Special Line Item Funds	Total Administrative Costs
Personal Services		\$12.3	\$158.2	\$109.8			\$280.3
Employee Related Benefits		3.0	39.2	14.5			56.8
Professional and Outside			1.1	0.1			1.2
Travel: In-State		2.4	5.0	6.9			14.2
Travel: Out-Of-State		(0.6)	0.6	0.4			0.4
Other Operating		1.7	11.4	10.7			23.8
Equipment							
Indirect							
		\$18.8	\$215.4	\$142.5			\$376.7

NOTES

- \1 Dollars are expressed in thousands, rounded to the nearest \$100.
- \2 Reverted dollars are available for FY 1997 administrative adjustment payments.
- \3 Administrative adjustment payments for FY 1996 made in FY 1997 are not included in this report.

Annual Report of Source and Use of Funds
For Fiscal Year Ending June 30, 1997

SERIOUSLY MENTALLY ILL

	Balance Carried Forward From FY 1996	FY 1997 Revenues	Transfers In	Transfers Out	FY 1997 Expenditures	Reverted To FY 1997	Balance Carried Forward To FY 1998
Non-General Fund Receipts	\$401.4	\$19,412.4			\$19,445.7		\$368.1
Federal Funds	(590.4)	392.8			352.7		(550.3)
Title XIX Federal Passthrough	559.7	30,385.2			30,051.3		893.7
General Appropriations		298.7			298.7		
Special Line Item Funds (Non-Reverting)		71,027.2			69,566.5	1,460.6	
Special Line Item Funds	\$370.7	\$121,516.4			\$119,715.0	\$1,460.6	\$711.5

ADHS/DBHS Administrative Costs

	Non-General Fund Receipts	Federal Funds	Title XIX Federal Passthrough	General Appropriations	Special Line Item Funds (Non-Reverting)	Special Line Item Funds	Total Administrative Costs
Personal Services		\$17.6	\$115.1	\$216.2			\$348.8
Employee Related Benefits		3.8	25.0	28.7			57.6
Professional and Outside		1.0	10.6	17.0			28.6
Travel: In-State		0.7	3.8	9.9			14.4
Travel: Out-Of-State		1.7	1.4	2.6			5.7
Other Operating		2.9	11.4	24.3			38.5
Equipment							
Indirect		0.1					0.1
		\$27.8	\$167.3	\$298.7			\$493.8

NOTES

- \1 Dollars are expressed in thousands, rounded to the nearest \$100.
- \2 Reverted dollars are available for FY 1997 administrative adjustment payments.
- \3 Administrative adjustment payments for FY 1996 made in FY 1997 are not included in this report.
- \4 ASH Community Placement is appropriated to ASH and is not included in this report. The amount expended for community placement from that fund during FY 1997 was \$4,880,000.

ADHS/DBHS

Annual Report of Source and Use of Funds For Fiscal Year Ending June 30, 1997

MENTAL HEALTH

	Balance Carried Forward From FY 1996	FY 1997 Revenues	Transfers In	Transfers Out	FY 1997 Expenditures	Reverted To FY 1997	Balance Carried Forward To FY 1998
Non-General Fund Receipts	\$698.8	\$5,773.9			\$5,500.0		\$972.6
Federal Funds		810.2			640.0		170.3
Title XIX Federal Passthrough	11.1	4,115.5			4,816.0		(689.5)
General Appropriations							
Special Line Item Funds (Non-Reverting)		11,040.5			10,711.3	329.3	
Special Line Item Funds	\$709.9	\$21,740.1			\$21,667.3	\$329.3	\$453.5

ADHS/DBHS Administrative Costs

	Title XIX		Special Line		Total	
	Non-General	Federal	General	Item Funds	Special Line	Administrative
Fund Receipts	Federal Funds	Passthrough	Appropriations	(Non-Reverting)	Item Funds	Costs
Personal Services						
Employee Related Benfits						
Professional and Outside						
Travel: In-State						
Travel: Out-Of-State						
Other Operating						
Equipment						
Indirect						

NOTES

- \1 Dollars are expressed in thousands, rounded to the nearest \$100.
- \2 Reverted dollars are available for FY 1997 administrative adjustment payments.
- \3 Administrative adjustment payments for FY 1996 made in FY 1997 are not included in this report.

ADHS/DBHS

Annual Report of Source and Use of Funds

For Fiscal Year Ending June 30, 1997

DRUG AND ALCOHOL ABUSE

Balance Carried Forward From FY 1996	FY 1997 Revenues	Transfers In	Transfers Out	FY 1997 Expenditures	Reverted To FY 1997	Balance Carried Forward To FY 1998
Non-General Fund Reciepts	\$494.7	\$3,494.5		\$2,893.7		\$1,095.5
Federal Funds	(65.7)	21,052.4		20,951.7		35.1
Title XIX Federal Passthrough		2,093.5		2,081.8		11.7
General Appropriations		168.4		168.4		
Special Line Item Funds (Non-Reverting)		12,062.0		11,789.4	272.5	
Special Line Item Funds	\$429.0	\$38,870.7		\$37,884.9	\$272.5	\$1,142.3

ADHS/DBHS Administrative Costs

Non-General Fund Reciepts	Federal Funds	Title XIX		General Appropriations	Special Line		Total
		Federal Passthrough			Item Funds (Non-Reverting)	Special Line Item Funds	
Personal Services	\$196.7	\$18.6		\$121.7			\$337.0
Employee Related Benfits	42.1	3.9		15.8			61.7
Professional and Outside	14.3	0.8		3.1			18.2
Travel: In-State	7.3	0.2		9.6			17.2
Travel: Out-Of-State	9.5			2.6			12.1
Other Operating	30.9	0.7		15.6			47.2
Equipment							
Indirect							
	\$300.9	\$24.2		\$168.4			\$493.4

NOTES

- \1 Dollars are expressed in thousands, rounded to the nearest \$100.
- \2 Reverted dollars are available for FY 1997 administrative adjustment payments.
- \3 Administrative adjustment payments for FY 1996 made in FY 1997 are not included in this report.

ADHS/DBHS

Annual Report of Source and Use of Funds

For Fiscal Year Ending June 30, 1997

DOMESTIC VIOLENCE

	Balance Carried Forward From FY 1996	FY 1997 Revenues	Transfers In	Transfers Out	FY 1997 Expenditures	Reverted To FY 1997	Balance Carried Forward To FY 1998
Non-General Fund Reciepts Federal Funds	(3.0)	218.4			304.3		(88.8)
Title XIX Federal Passthrough General Appropriations							
Special Line Item Funds (Non-Reverting)							
Special Line Item Funds							
	(\$3.0)	\$218.4			\$304.3		(\$88.8)

ADHS/DBHS Administrative Costs

	Non-General Fund Reciepts	Federal Funds	Title XIX Federal Passthrough	General Appropriations	Special Line Item Funds (Non-Reverting)	Special Line Item Funds	Total Administrative Costs
Personal Services							
Employee Related Benfits							
Professional and Outside							
Travel: In-State							
Travel: Out-Of-State							
Other Operating							
Equipment							
Indirect							

NOTES

- \1 Dollars are expressed in thousands, rounded to the nearest \$100.
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Annual Report of Source and Use of Funds

For Fiscal Year Ending June 30, 1997

SOUTHERN ARIZONA MENTAL HEALTH CENTER

	Balance Carried Forward From FY 1996	FY 1997 Revenues	Transfers In	Transfers Out	FY 1997 Expenditures	Reverted To FY 1997	Balance Carried Forward To FY 1998
Non-General Fund Reciepts	\$482.2	\$746.3			\$772.5		\$455.9
Federal Funds							
Title XIX Federal Passthrough							
General Appropriations							
Special Line Item Funds (Non-Reverting)							
Special Line Item Funds							
	\$482.2	\$746.3			\$772.5		\$455.9

ADHS/DBHS Administrative Costs

	Non-General Fund Reciepts	Federal Funds	Title XIX Federal Passthrough	General Appropriations	Special Line Item Funds (Non-Reverting)	Special Line Item Funds	Total Administrative Costs
Personal Services							
Employee Related Benfits							
Professional and Outside							
Travel: In-State							
Travel: Out-Of-State							
Other Operating							
Equipment							
Indirect							

NOTES

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- \2 Reverted dollars are available for FY 1997 administrative adjustment payments.
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ADHS/DBHS

Annual Report of Source and Use of Funds

For Fiscal Year Ending June 30, 1997

TOBACCO TAX

	Balance Carried Forward From FY 1996	FY 1997 Revenues	Transfers In	Transfers Out	FY 1997 Expenditures	Reverted To FY 1997	Balance Carried Forward To FY 1998
Non-General Fund Reciepts Federal Funds		\$5,500.0			\$5,500.0		
Title XIX Federal Passthrough General Appropriations							
Special Line Item Funds (Non-Reverting)							
Special Line Item Funds		\$5,500.0			\$5,500.0		

ADHS/DBHS Administrative Costs

	Non-General Fund Reciepts	Federal Funds	Title XIX Federal Passthrough	General Appropriations	Special Line Item Funds (Non-Reverting)	Special Line Item Funds	Total Administrative Costs
Personal Services							
Employee Related Benefits							
Professional and Outside							
Travel: In-State							
Travel: Out-Of-State							
Other Operating							
Equipment							
Indirect							

NOTES

- \1 Dollars are expressed in thousands, rounded to the nearest \$100.
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Annual Report of Source and Use of Funds

For Fiscal Year Ending June 30, 1997

ADMINISTRATION & OVERSIGHT

	Balance Carried Forward From FY 1996	FY 1997 Revenues	Transfers In	Transfers Out	FY 1997 Expenditures	Reverted To FY 1997	Balance Carried Forward To FY 1998
Non-General Fund Reciepts		\$313.7			\$313.7		
Federal Funds	(34.5)	\$435.7			\$435.7		(34.5)
Title XIX Federal Passthrough	424.9	1,782.4			1,338.3		869.0
General Appropriations		3,085.3			2,561.5	523.8	
Special Line Item Funds (Non-Reverting)							
Special Line Item Funds		6,039.9			4,884.7	1,155.2	
	\$390.4	\$11,657.0			\$9,533.9	\$1,679.0	\$834.5

ADHS/DBHS Administrative Costs

	Title XIX		Special Line		Total	
	Non-General	Federal	General	Special Line	Administrative	
	Fund Reciepts	Federal Funds	Appropriations	Item Funds (Non-Reverting)	Item Funds	Costs
Personal Services						
Employee Related Benefits						
Professional and Outside						
Travel: In-State						
Travel: Out-Of-State						
Other Operating						
Equipment						
Indirect						

NOTES

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- \2 Reverted dollars are available for FY 1997 administrative adjustment payments.
- \3 Administrative adjustment payments for FY 1996 made in FY 1997 are not included in this report.

ADHS/DBHS

Annual Report of Source and Use of Funds

For Fiscal Year Ending June 30, 1997

SUMMARY

	Balance Carried Forward From FY 1996	FY 1997 Revenues	Transfers In	Transfers Out	FY 1997 Expenditures	Reverted To FY 1997	Balance Carried Forward To FY 1998
Non-General Fund Reciepts	\$2,176.5	\$36,890.6			\$36,141.9		\$2,925.2
Federal Funds	(803.2)	26,053.7			25,966.2		(715.7)
Title XIX Federal Passthrough	1,157.3	71,398.0			71,462.9		1,092.4
General Appropriations		3,694.9			3,171.1	523.8	
Special Line Item Funds (Non-Reverting)		137,895.8			133,036.5	4,859.3	
Special Line Item Funds	\$2,530.6	\$275,932.9			\$269,778.6	\$5,383.1	\$3,301.9

ADHS/DBHS Administrative Costs

	Non-General Fund Reciepts	Federal Funds	Title XIX Federal Passthrough	General Appropriations	Special Line Item Funds (Non-Reverting)	Special Line Item Funds	Total Administrative Costs
Personal Services		\$226.6	\$291.8	\$447.7			\$966.1
Employee Related Benfits		48.9	68.1	59.1			176.1
Professional and Outside		15.3	12.5	20.3			48.1
Travel: In-State		10.4	9.0	26.4			45.8
Travel: Out-Of-State		10.6	2.0	5.6			18.2
Other Operating		35.5	23.5	50.6			109.5
Equipment							
Indirect		0.1					0.1
		\$347.5	\$406.9	\$609.6			\$1,363.9

NOTES

- \1 Dollars are expressed in thousands, rounded to the nearest \$100.
- \2 Reverted dollars are available for FY 1997 administrative adjustment payments.
- \3 Administrative adjustment payments for FY 1996 made in FY 1997 are not included in this report.
- \4 Administrative adjustment payments paid in FY 1997 for FY 1994 and FY 1996 amounted to \$4,146,700.



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